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ABSTRACT

This document contains the text of three hearings which constitute part one of the Congressional hearings held to examine reauthorization of the Older Americans Act. It provides an historical overview of the Older Americans Act of 1965 and discusses various issues involved in the reauthorization. Opening statements are included from Representatives Dale Kildee, Mario Biaggi, Thomas Tauke, and Fred Grandy. Witnesses providing testimony include: (1) Dolores Battle, United States Department of Labor; (2) William Bechill, former United States Commissioner on Aging; (3) Elaine Brody, Philadelphia Geriatric Center; (4) Sonia Crow, Food and Nutrition Service, Department of Agriculture; (5) Jill Duson, president, National Association of State Long Term Care Ombudsman Programs; (6) Toby Felcher, Association of Nutrition and Aging Services Programs; (7) Carol Fraser Fisk, Commissioner on Aging; (8) John Paul Hammerschmidt, Congressman from Arkansas; (9) William Hutton, National Council of Senior Citizens; (10) Eugene Lehrmann, American Association of Retired Persons; (11) Donna McDowell, Wisconsin Bureau of Aging; (12) Russell Proffitt, National Association of Area Agencies on Aging; (13) Donald Reilly, National Council on Aging; (14) Samuel Simmons, National Caucus and Center on Black Aged, Inc.; and (15) Ron Wyden, Congressman from Oregon. Prepared statements, letters, and supplemental materials are included. (NB)

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REAUTHORIZATION HEARINGS ON THE OLDER AMERICANS ACT

Part 1

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON EDUCATION AND LABOR
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

HEARINGS HELD IN WASHINGTON, DC, ON MARCH 9, 23; AND APRIL 6, 1987

Serial No. 100-18

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REAUTHORIZATION HEARINGS ON THE OLDER AMERICANS ACT

Part 1

MONDAY, MARCH 9, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m. in room 2261, Rayburn House Office Building, Hon. Dale E. Kildee presiding.

Members present. Representatives Kildee, Biaggi, Solarz, Visclosky, Tauke and Grandy.

Staff present. Susan A. Wilhelm, staff director; Thomas Kelley, legislative associate; Margaret Kajeckas, clerk; and Carol Lamb, minority legislative associate.

Mr. **Kildee**. The Subcommittee will come to order. The Subcommittee on Human Resources meets this morning for the first of three hearings on reauthorization of the Older Americans Act.

Older Americans Act programs provide the lifeline that enables the elderly to live independently in their communities—whether it be transportation services, homemaker services, congregate or home delivered meals.

My own mother, who is 87 years old, has delivered, once a day, five days a week, a meal to her home. She pays for that meal, but it is extremely important to her, being 87. I think her health is maintained a great deal because she does have that one guaranteed well balanced meal. Very often, what happens is that a person does not feel well and they do not prepare their meals, so they get even further deterioration in their health—it keeps going down and down. My mother, a few years ago, fell and broke her pelvis, and on her return to her home, where she was very happy to be, that one meal a day made a real difference in her life.

I think many of us are immediately touched by people in our lives who have benefited from the programs that are delivered under the umbrella of the Older Americans Act.

We have senior citizen activities and senior centers, and some we actually help find employment through the Community Services Employment Program. So, the Older Americans Act does provide opportunities that enable the elderly to continue to be active participants in the community. I know my mother is very active, she is really a participant. She is not isolated because of these programs.

The Older Americans Act and the programs it authorizes are among the most successful of any federal programs currently operating. Although older persons may receive services under other federal programs, this act is the major vehicle for the organization and delivery of social services to this group.

The fact that the Act has been overwhelmingly reauthorized many times since 1965 attests to the strong bipartisan support it enjoys as well as to its effectiveness. I had the pleasure of traveling to Tom Tauke's district last year where he showed us many of the programs out there that work well. Mr. Tauke has been a strong supporter of this program.

Today's hearing will provide an historical overview of the Act and we will also begin discussion on various issues involved in the reauthorization of the Act. I am going to use a quote today that I use frequently, you have heard it often. But from time to time in reading scripture, we read the same verses from time to time to reenergize ourselves and reinspire ourselves. I think that one of my great heroes in government was Hubert Humphrey, he really gave us a sensitivity to how government should respond. I believe that government's prime function is to promote, protect, defend, and enhance human dignity. For every bill that comes before the Congress of the United States, I try to ask myself—will it do that, will it promote, protect, defend, or enhance human dignity or will it tend to denegrate human dignity. We all have asked that various times, and I am asking it again today.

As I read over the weekend, money appropriated by the Congress of the United States was used to destroy a health clinic run by a church in Nicaragua. We have to ask ourselves—was the appropriation of that money designed to promote, protect, defend, and enhance human dignity? Is destroying a health clinic a function of the United States Government?

We have to ask ourselves those questions. I like to build health clinics, not destroy them.

Hubert Humphrey told us, "the test of a government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadow of life, the sick, the needy, and the handicapped."

Most of us in this room will survive no matter what government may do. Most of us here will. But the more vulnerable people in our society need a very sensitive and compassionate government. The young are vulnerable, the old are vulnerable, and those who are deprived of the basic needs of life are vulnerable. This subcommittee has under its charge the responsibility for the most vulnerable people in our society and we are determined to make this a sensitive, compassionate subcommittee so that this government will be more sensitive and more compassionate.

We welcome the witnesses here this morning for that purpose.

Mr. Biaggi, do you have an opening statement?

Mr. **Biaggi**. Yes, thank you, Mr. Chairman.

Gentlemen, permit me to congratulate you for an expeditious embarkation on this reauthorization of the Older Americans Act. Truly you have demonstrated in the past your concern, and I am delighted to join with you in this committee today and my colleagues to do it once again.

Although I am a new member of this subcommittee, I have been involved in the Older Americans Act for some time. In fact, this will be my ninth reauthorization. I have worked on over 11 of the acts I have had over this 22-year period. I have maintained my activity on behalf of the Older Americans Act not only as a member of the full committee, but for the past 10 years as Chairman of the House Select Committee on Aging Subcommittee on Human Services. My subcommittee, together with this distinguished panel, has oversight responsibility over the Older Americans Act.

I would note for the record that my Subcommittee on Human Services has conducted five hearings already on the upcoming 1987 reauthorization in Washington, California, and New York. The sentiment that we received from more than 30 different witnesses is that the Act is operating well and does not need radical surgery as part of this reauthorization.

I will be proud to join, as an original co-sponsor a four year reauthorization. I wholeheartedly agree with his approach of the process, namely to get a bill early in the session and allow members of the subcommittee and full committee of not only the opportunity for careful scrutiny in change—it remains my firm belief that the reauthorization process should produce a fine tuning of the law for the coming four years. We should not either over or underestimate the term of fine tuning. There are obvious areas whêre the Act must be modified to adopt the changing needs. Yet there are equally as obvious areas where tampering with something that is working can only create problems.

I know that in my role as member of the subcommittee, I will work to make sure that the fine tuning we do allows the programs to run better.

The major issue as outlined in the Chairman's memorandum, to me, represent an accurate assessment of this point. I especially support the idea of elevating the status of Commission on Aging, a position I have advocated over the years. The current state of the administration on aging, within HHS—is discraceful and we must make changes to improve this. I strongly support efforts to broaden the responsibilities as well as the funding base for the Long Term Care Ombudsman Programs authorized under the Older Americans Act. Let us not loose sight of the important function that the ombudsman plays. They have the responsibility to take complaints of elderly residents in long-term facilities and report them to those entities at the state level who can correct the problem.

It is very obvious that we need to improve our present targeting procedures under the Older Americans Act. The law states that those elderly with the greatest economic or social need are to be given priority consideration for services provided. Yet today there continues to show, at best, one out of every two seniors served come from those with greatest economic or social need. That also points to a steady drop in participation by minority aging which warrants not only our attention but action.

The issue of whether we should restore specific percentage set-asides under Title III-B where priority service is promised promises to occupy a good deal of this subcommittee's time during the reauthorization. My subcommittee held a specific hearing on one of these three services—legal assistance and services. We were presented with a special white paper prepared by the entities in the American Bar Association, the National Senior Citizen Law Center, and the American Association of Retired Persons. They made a persuasive case for restoring a set-aside. Yet, we must look at this from the broader perspective—namely, whether we want to alter the basic philosophy of the Act, that decisions are best made at the state and local level through the aging network. I know my mind is still open on this point.

Other issues I am anxious to have discussed today would include the entire issue of how we now solicit voluntary contributions for nutrition services under Title III and whether it should be expanded to include Title III-B services. I have a special interest in the new discussion about case management and whether agencies on aging should be able to provide this as a direct service without a waiver from the state.

With respect to Title IV, the two issues of particular interest relate to administrative cost—whether they should be raised, lowered or frozen and also whether their rolling costs need to be considered in making funding determinations.

Last, and certainly not least—among my earlier insterests is a proposal I am having developed which would create a new Title III-B2, which would expand the Older Americans Act commitment to providing supportive services to victims of Alzheimers Disease as well as their families. The initial authorities of this was provided in the 1984 reauthorization as a new allowable service under Title III-B. Successful programs have been established since that time which deserve the additional assistance my proposal would give them. I look forward to further discussion on this in the coming weeks.

Again, Mr. Chairman, let me again express my delight in being here this morning for this first hearing. It appears that the reauthorization road looks pretty clear of obstacles. I look forward to working with you.

I also look forward to hearing from our distinguished witnesses—Professor Bechill, the resident authority on the Older Americans Act; Jill Duson from Maine, the leading spokesman for the Long Term Ombudsman Program; Toby Felcher from Baltimore, a national officer for the National Association of Nutrition and Aging Service Program, a group I have worked very closely with; Donna McDowell from Wisconsin, a long-time leader of the National Association of State Units on Aging; and last but not least, my friend Russel Proffitt, from Cedar Rapids, Iowa, who for years has kept me advised on the concerns of area agencies on aging.

Thank you—I thank them all for coming and thank you, Mr. Chairman.

Mr. KILDEE. Thank you, Mr. Biaggi.

The ranking Republican member of the committee and a long-time friend of senior citizens, Tom Tauke.

Mr. TAUKE. Thank you, Mr. Chairman. Mr. Chairman, it certainly is good to have an opportunity to again work with you in this Congress on this subcommittee. As you indicated during the course of your opening comments, we on the subcommittee deal with the concerns of those who are most vulnerable in our society, and those individuals in our society could not have a stronger champion than you. It is a great pleasure and honor for me to have the opportunity again in this Congress to work with you to attempt to address some of the needs of individuals who are most needy in our nation.

I also look forward to working with the other members of the subcommittee and, if I just may observe, Mr. Chairman, we have four members on our side of the aisle on the subcommittee this year. Mr. Coleman and Mr. Jeffords are unable to be here at the moment, but we have a new member also, Mr. Grandy from Iowa. And having two Iowans on the subcommittee may be more than someone from Michigan can handle, but at least until the football season, we will probably be able to. [Laughter.]

I might say we felt better the second time we played you in the basketball season than the first this year.

The aging network that has emerged around the Older Americans Act, as it has developed throughout the years, will be faced with new challenges in the 1990s and beyond. It is important, I think, to adjust the Older Americans Act now to ensure that the network is in a position to meet those challenges. The challenges are created in large part by three trends in the environment which we must recognize as we reauthorize the Older Americans Act this year.

The first trend is that the elderly population in the United States is going to grow very significantly over the next few decades. The baby boom is aging and life expectancy continues to increase. Between now and the year 2010, the number of elderly citizens in our society is expected to increase by 10.6 million. Most of this increase will occur in the age 80 and above group. As a result, we will have a higher number of elderly citizens in the 80 and above group and, as you know, many of those are frail elderly.

The second change that is occurring is that more women who are traditionally the primary care givers for the elderly working full time. As women's work patterns continue to change, the ready pool of care givers for the elderly will be depleted. As that ready pool of care givers for the frail elderly is depleted, we will face new challenges.

The third trend is that the elderly population is becoming less homogeneous and more heterogeneous. We must recognize that there are vast differences within the elderly population. Some of our senior citizens are frail, they are home-bound. Others are vigorous and very active. Some are quite well-to-do, from a financial perspective. Others have very little income. It occurs to me that as we put together a new reauthorization bill for the Older Americans Act that it is important that we try to serve all segments of the elderly population. At the same time, Mr. Chairman, I am hoping this year that we can focus special attention on the frail elderly, particularly those who are home-bound and need in-home services.

I commend the groups that are represented here today for their efforts to confront all of these changes and to develop innovative approaches to address the growing demands being placed on Older Americans Act programs. I am looking forward to working with all of these organizations and many others to develop this year's reauthorization legislation.

I want to offer a special welcome, Mr. Chairman, to one of my own constituents, Russ Proffitt, who is the Director of the Heritage

Area Agency on Aging in Cedar Rapids and is today representing the National Association of Area Agencies on Aging. I am sure that his comments and the comments of our other witnesses will be very helpful to us in getting off on the right foot as we begin this reauthorization process. Thank you.

Mr. **Kildee**. Thank you, Tom.

Mr. Solarz, do you have an opening statement or comments?

Mr. **Solarz**. No, thank you.

Mr. **Kildee**. Mr. Grandy?

Mr. **Grandy**. Thank you, Mr. Chairman. I just want to say that I am delighted that there are two members from the State of Iowa on this particular committee because I think that in the rural states, particularly agricultural states, there is a growing need for these kinds of programs and a growing need, perhaps, for greater representation. I represent a district with a very high elderly population and am pleased to hear the testimony of these professionals in the field of aging. Indeed, in Iowa right now, as we see the drain of our population on our tax base out of the state, the reality is that we are losing a lot of our people and are left with those folks over 65 and under 13, which are, as you know, the main recipients of federal programs.

But during the past couple years, I have had the opportunity of visiting with our senior citizens in the senior centers and at the congregate meals and can say without a doubt that the activities of the senior centers and the congregate meal programs are the center of activity in many small rural communities and provide the type of social stimulation which our elderly population has grown to rely on in their golden years. Without these services and activities, the lives of many elderly people would be lacking the interaction which is very important to them, to say nothing of the services that provide nutritious meals.

Many of the aging agencies offer programs which allow the elderly to continue to use their skills for the good of themselves and the community around them. The lives of America's elderly have certainly been enhanced by these programs under the Older Americans Act and again I am happy to be here to discuss how we can improve the lives of our older citizens and look forward to the words of our guests who are before us today.

I will just add that I am particularly delighted to see the initiatives for in-home care. Again, this is perhaps a problem that is felt more intensely in rural communities as we see the decline of our own health care network. The need for in-home service for the elderly and the frail is even greater.

I am also glad to see attention being paid finally and publicly to Alzheimers Disease, particularly among those folks that are now called the old old—and I hope that this committee will focus a lot of attention in the weeks to come.

Mr. Chairman, just finally, I am glad to be part of this committee. I sought this subcommittee and I hope that with our actions today and in the weeks ahead we will be able to provide a need for people that clearly are on the under-side of society. I would say, finally, that it is a privilege to be on a committee such as Education and Labor where you can actually see your programs working.

Chapter 1 is an obvious example and the Older Americans Act is clearly another.

Thank you for the opportunity.

Mr. KILDEE. Thank you, Mr. Grandy.

Mr. Visclosky?

Mr. VISCLOSKY. Thank you, Mr. Chairman, I have no comment at this time.

Mr. KILDEE. All right, thank you very much.

Our first witness this morning is Professor William Bechill. Professor Bechill served as the first Commissioner on Aging from 1965 to 1969, and is currently teaching at the School of Social Work and Community Planning at the University of Maryland at Baltimore.

Mr. Bechill, if you could step forward, please. Your entire written testimony will be made part of the record. If you wish to summarize, you may do so.

STATEMENT OF PROFESSOR WILLIAM D. BECHILL, FORMER U.S. COMMISSIONER ON AGING [1965-1969], ASSOCIATE PROFESSOR, SCHOOL OF SOCIAL WORK AND COMMUNITY PLANNING AT THE UNIVERSITY OF MARYLAND AT BALTIMORE

Mr. BECHILL. With your permission, I will summarize.

Mr. KILDEE. Very good. We encourage that, as a matter of fact.

Mr. BECHILL. Mr. Chairman and members of the Subcommittee, thank you very much for your invitation to appear before you today. These hearings on the reauthorization of the Older Americans Act are very important and I hope my testimony will be of some assistance to you.

I am very honored to be appearing before the House Education and Labor Committee again. This committee has a long and very proud history of giving strong and creative support for the programs of the Older Americans Act. When I served as Commissioner, I always had the full backing and support, particularly of the Chairman of the overall committee, who was then Mr. Carl Perkins of Kentucky. I had support from both sides of the aisle, always in terms of the interest in the program, and I think that has been the case over the years, strong bipartisan support for the programs. It is also good to see Mr. Biaggi here and I know that the important role that he has played over the years in bringing the program to its present scope.

Mr. Chairman, in your testimony you asked me to provide you with some background information about the original intent of the Older Americans Act and the development of the Older Americans Act legislation.

The Older Americans Act was signed into law by President Johnson on July 14, 1965. The law was also popularly known to those of us working in the field of aging at that time as the Fogarty-McNamara Act. It was overwhelmingly adopted by both houses of the Congress. The vote in the House on March 31 on H.R. 3708 was 30—391 to one, and this is the journal—March 31 journal of the Congressional Record. H.R. 3708 was also the bill acted upon later in the Senate.

The principle authors were the late Representative John Fogarty of Rhode Island and the late Senator from the State of Michigan, Pat McNamara. The Act emerged out of the strong interest on both the parts of Mr. John Fogarty and Senator McNamara about the problems being faced by older people in our country. Mr. Fogarty introduced legislation early in 1958 known as the White House Conference on Aging Act, which was passed in August of 1958.

The White House Conference on Aging held in 1961 produced about 600 recommendations calling for national, state and local action on behalf of older people. And one of those recommendations was called for the establishment of an independent agency solely concerned with the needs and interests of older people.

The Older Americans Act of 1965 represented the implementation of this recommendation of the 1961 White House Conference on Aging, and the original Act included six titles. The first was a ten point Declaration of Objectives for all older americans and then there were five other titles. I have also the original Act with me. Here is the original act, which is a—was an eight page document.

The original authorizations for the Act were five million in fiscal year 1966 and eight million for fiscal year 1969 for Title III and 1.5 million for fiscal year 1968 and three million for fiscal year 1967 for Titles IV and V, IV and V being the titles for research demonstration and V being the title then for training.

If I could summarize the original intent of the Act, the main authors' intent, first they wanted a strong and visible agency within the Executive Branch that could concentrate solely on the needs and interests of older people. Second, they wanted that agency not to be seen as a welfare program. Third, they wanted—Mr. Fogarty, especially—a national blueprint for action to be developed and prepared by the Administration on Aging. And, finally, they were very much interested in the development of improved state and local programs and services for and with older people.

Let me turn to the evolution of the Act. Since 1965, the Act has been amended—in 1967, 1969, 1972, 1973, 1974, 1975, 1981, and 1984. To me, the turning points in terms of the Older American Act programs, although there has been a constant evolution, were the legislation enacted in 1972 and 1973. In the 1972 Amendments, the Congress added a new title for the Older Americans Act in the National Nutrition Program—100 million for the first year, 150 million for the second year. That program marked the first time that the Administration on Aging had been given the responsibility for the provision of a large scale program of services.

The congregate meals nutrition program established under the old former Title VII has proven not only to be a politically popular program but one that has been very cost effective and often served as the base for a broader program of community services for older people.

The 1973 legislation is really, in my opinion and the opinion of many others who have looked at this Act over the years, the watershed legislation. Because under that—those particular amendments, the goal of the development of comprehensive and coordinated services for older people was built into the language of the law as an objective of the Title III program. Those amendments also called for the establishment of Area Agencies on Aging with the related emphasis on area planning, the permanent establishment of the Older Americans Act Community Service Employment Program which is now Title V of the Act, and what sometimes is overlooked in reviewing the 1973 legislation, amendments that were designed to clarify in some detail the functions of the Commissioner on Aging and of the Administration on Aging.

While each of the changes since the 1973 Amendments, which I will not detail here, have expanded the authorizations of the Act, my observations have been that the Congress has increasingly moved towards provisions that would emphasize that the programs and services of the Act, especially under Title III, be targeted against the needs of older people who are either living in or near poverty, are the minority aging, are in risk of institutionalization, or are living in social isolation as the law and regulations define.

Yet, as the Congress has moved in this direction, my observation—and this is only a personal observation, it represents no organizational point of view, I am here as an individual—is that it has moved with some caution. You should know that the Act has a long history of its services being available to all older people. The introduction of an income test or a means test for services rendered under the Act, as some have proposed in the past and may be proposing currently, would meet, in my opinion, with strong resistance, especially by organizations representing older people.

Since the 1973 Amendments, we have seen the emergence of a aging network, a very vital aging network, some 56 state agencies on aging, 675 area agencies on aging, and many other components. This concept of an aging network was particularly built during the five-year tenure of Dr. Arthur Flemming when he served as Commissioner from 1973 to early 1978.

The network is real, it exists. It is, in the most literal sense, a system in every state that involves planning, coordination, the provision of various services and advocacy on behalf of older people. In 1985, the authorizations for the Older Americans Act program totalled some $1.3 billion; the actual appropriations were some $1.1 billion for the various programs of the act.

I mentioned some criticisms of the Act. I do not want to dwell on these, but there are at least two or three that I would like to mention that I know are of some concern to you and possibly to the field itself.

One is that from the inception of the program, AoA has met with criticism for its performance as a visible advocate for older people within the Federal Government. All of us who have served as Commissioner have attempted to carry out this advocacy function but it has always been a difficult role to perform and I am glad that you are going to be looking at that role again, and I noticed the comments that Mr. Biaggi made with respect to his proposed amendments.

Second, some administrators in the aging network have questioned how well the goal of developing comprehensive and coordinated systems of services has been met. It is a very understandable question to raise since this is the overall goal. Based on my review of the implementation of the Older Americans Act in Maryland, especially the area planning process, I believe there has been real movement to more comprehensive planning and services.

Third, it was an oversight on my part in preparing this testimony not to mention another issue of concern to me, and that is the decline of minority aging being served under the Title III program. This is a serious issue and one that warrants some priority attention during these reauthorization hearings.

Mr. Chairman and members, it seems to me that there is even a more compelling need for the Older Americans Act now than there was 22 years ago when Mr. Fogarty and Senator McNamara and others in the Congress had the vision to enact the original law. We are fast approaching what has been termed by many as the aging society. It will be a society where about one out of every five Americans will be an older person. It will be one which will have a profound impact on every social, and economic institution in the country. It will be one that will include an older population that will be multi-generational involving, simultaneously, an increase in healthy, vigorous and talented individuals as well as an increase of those who, because of advanced age, will have some moderate or severe functional impairment, and it will increasingly be a population that will be living longer since future gains in life expectancy can be anticipated.

I respectfully urge you to reauthorize the Older Americans Act in ways that you believe will strengthen and expand the visions of Titles III, IV, V and VI of the Act. With regards to Title III, I urge you to continue the separate authorizations for senior centers and supportive services, the congregate meals nutrition program, and the home delivered meals program.

I hope that you will wish to place additional emphasis on increasing the availability of in-home services under the Title III program. And I also hope you will look favorably on proposals that may be made to give state and area agencies on aging a greater role in the development of community based long-term care services.

With regards to Title IV, I request that you continue the authorizations for research, development and training grants. These discretionary grants are especially important for the Commissioner on Aging to have at her disposal to provide thoughtful national leadership. I also urge continuation and expansion of the Title V and Title VI program.

The Title V program has a long and successful history of providing employment opportunities for low-income older people in a number of important human settings.

And finally, I urge you to reaffirm the importance of the Older Americans Act Personal Health and Education program authorized under Title VII of the 1984 Amendments. There have been no appropriations made for that authorization. The title's goal is still very valid—a major preventative health services and education program aimed at helping older people better understand a number of basic health problems.

Thank you, again, for inviting me here. I will be very glad to respond to any questions or provide any additional information on the points covered in my testimony. I am very honored to be here.

[Prepared statement of William D. Bechill follows:]

PREPARED STATEMENT OF WILLIAM D. BECHILL, SCHOOL OF SOCIAL WORK AND COMMUNITY PLANNING, UNIVERSITY OF MARYLAND AT BALTIMORE

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for your invitation to appear before you today. These hearings on the reauthorization of the Older Americans Act are very important, and I hope that my testimony will be of assistance to the Subcommittee.

I am especially honored to be the lead off witness for today's hearing. I served as the first Commissioner on Aging during the Johnson Administration. Since leaving the government in 1969, the development of the Older Americans Act has been a major interest of mine, both personally and professionally. In my view, the Act ranks, along with the initial Social Security Act legislation in 1935 and the Medicare legislation of 1965, as one of the most important pieces of social legislation in our national history.

Mr. Chairman, I am also honored to be appearing before this subcommittee again. The House Education and Labor Committee has a long and proud history of interest and creative support for the programs of the Older Americans Act.

In your invitation, Mr. Chairman, you asked me to provide testimony that would increase the Subcommittee's understanding of the history behind the Act's original enactment in 1965 and the developments that have occurred since that time. In addition, you indicated an interest in having my views on the future directions of the Act.

1. History of the Older Americans Act of 1965

The Older Americans Act of 1965, P.L. 89-73, was signed into law by President Johnson on July 14, 1965. The law, also called the Fogarty-McNamara Act, was overwhelmingly adopted by both houses of the Congress. The vote in the House on March 31, 1965 on H.R. 3708 was 391 to 1, H.R. 3708 also was the bill acted upon later by the Senate.

As you know, the principal authors were the late Representative John Fogarty of Rhode Island and the late Senator Patrick McNamara of Michigan. The Act emerged out of a strong interest on the part of both Mr. Fogarty and Senator McNamara about the problems being faced by older people in the United States. Mr. Fogarty, for instance, introduced legislation early in 1958, known as the White House Conference on Aging Act, which was enacted in August, 1958. The White House Conference on Aging held in January, 1961, produced a wide range of recommendations calling for national, state, and local actions on behalf of older people. One of those recommendations called for the establishment of an independent agency solely concerned with the needs of the older people that would serve as a Federal coordinating agency in the field of aging; have the Congress; and be responsible for periodic assessment and review of the various Federal programs serving older people.

The Older Americans Act of 1965 represented the implementation of these recommendations of the 1961 White House Conference on Aging. The original Act included six titles. The first was a ten point Declaration of Objectives for all older Americans. Title II established the Administration on Aging as an independent agency, headed by a Commissioner on Aging, in the Department of Health, Education and Welfare. Title III authorized a program of grants to the States for community services, planning, and training. Title IV authorized research and development projects, including those that would demonstrate new approaches, including the use of multipurpose activity centers, in serving older persons and also new approaches and methods to improving community coordination of services. Title V authorized projects for the specialized training of personnel to work in the field of aging. The final Title, VI, established a 15 member Advisory Committee on Older Americans, chaired by the Commissioner on Aging. The original authorizations for the Act were $5 million in fiscal year 1966 and $8 million for fiscal year 1967 for Title III, and $1.5 million for fiscal year 1966 and $3 million 1967 for Titles IV and V.

If I could capsulate the original Act, it seems that the original intent of the main authors of the Act was four-fold. First, they wanted a strong and visible agency within the

Executive Branch that could concentrate solely on the needs and interests of older people. Second, they wanted that agency not to be seen as a "welfare" program. Third, they wanted, Mr. Fogarty especially, a "national blueprint for action" to be developed and promoted by the Administration on Aging. Finally, they were very much interested in the development of improved State and local programs and services for and with older people.

2. The Evolution of the Act

The Older Americans Act has undergone a remarkable tranformation since its original enactment. Beginning in 1967, the Congress added amendments in 1969, 1973, 1974, 1975, 1978, 1981, and 1984 that have greatly expanded the scope and the authority of the Older Americans Act.

To me, the major turning points were the 1972 and 1973 Amendments. In March, 1972, the congress enacted the national Nutrition Program for the Elderly by adding a new title to the Act. Under its provisions, Congress authorized $100 million for the first year of a congregate nutrition program; $150 million for the second year. The nutrition program marked the first time that the Administration on Aging (AoA) had been given the responsibility for the provision of a large-scale program of direct services. The congregate meals nutrition program established under Title VII has proven to be not only a politically popular program, but one that has been both very cost-effective and often served as the base for a broader program of community-based services for older people.

However, it was the Older Americans Comprehensive Services Amendments of 1973 that really is the watershed legislation in the history.of the Act. Under the 1973 Amendments, several new features were added to the Act. Among the most significant were those that authorized the development of comprehensive and coordinated systems of services for older persons in every State, the establishment of area agencies on aging with a related emphasis on area planning, a new grant program for the development of multipurpose senior centers, the permanent establishment of an Older Americans Act Community Services Employment program, and, what often is overlooked, amendments designed to clarify and delineate, in some detail, the functions of the Commissioner on Aging. Section 202 of the current Act is essentially that which was adopted in the 1973 Admendments.

Since the 1973 Amendments, the Congress, of course, have made other changes which I will not detail here. While each change has expanded the authorizations of the Act, my observations, as well as others, has been that the Congress has increasingly moved towards provisions that would emphasize the programs and services of the Act, especially under Title III, be targeted against the needs of older people who are either living in or near poverty, are the minority aging, are in risk of institutionalization or are living in social isolation. Yet, as the Congress has moved in this direction, my observation is that it has moved with some caution. You should know that the Act has a long history of its services being available to all older persons. The introduction of an income test or means test for services rendered under the Act, as some have proposed, would meet, in my opinion, with strong resistance, especially by organizations representing older people.

Since the 1973 Amendments, literally we have seen the emergence of (a) "aging network" that consists of the AoA, some 56 state agencies on aging, some 675 area agencies on aging, over 1,250 nutrition projects, an estimated 3,000 senior centers that receive funding under the Title III provisions of the Act, and other organizations, including national organizations in the field of aging and colleges and universitites with training programs in various aspects of gerontology and geriatrics. This concept of an "aging network" were particulary built during the five year tenure of Dr. Arthur Flemming as Commissioner on Aging from 1973 to 1978. The "network" is real. It is, in the most literal sense, a system that involves planning, coordination, the provision of various service, and advocacy on behalf of the needs of older people. In 1985, the authorizations for the Older Americans Act programs totalled some $1.3 billion dollars; the actual appropriations some $1.1 billion was for the various programs of the Act.

3. Criticism of the "Aging Network"

I would not wish to suggest that smooth sailing has accompanied the growth of the Older Americans Act. Over the years, the Act, has had both internal and external critics.

For one thing, from the inception of the program. the Administration on Aging has met with periodic criticism for its performance as a visible advocate for older people within the Federal Government. All of us who have served as Commissioner, have attempted to carry out this advocacy function, but it has always been a difficult role to perform. To do it well, the Commissioner on Aging needs the resources to engage in-depth policy analysis and policy development as well as a strong conviction about the importance of the advocacy role.

Second, some administrators in the "aging network" have questioned how well the goal of developing comprehensive and coordinated systems of services has been met in the Title III program. It is an understandable question to raise since this is the overall goal of that title of the Act. Based on my review of the implementation of the Older Americans Act in Maryland, especially the area planning process, I believe that there has been real movement to more comprehensive planning and services, including some interesting and innovative ways to assure improved coordination of services.

For example, the Maryland Office on Aging, in cooperation with other state and local agencies, has launched two highly successful programs, called Gateway I and Gateway II,. Gateway I is a statewide program designed to improve access of older persons to aging services and program. Gateway I exists in every jurisdiction of the State, and Gateway I is usually located at a multi-purpose senior center site. It is an information and referral service that is in effect on a 24-hour basis, with arrangements made for after hours, weekend, and emergency calls. According to the Maryland Office on Aging, the program served 14,260 older persons in fiscal year 1985, and they are anticipating future growth in the program.

By contrast, Gateway II is a statewide long-term care program which serves moderately and severely health impaired persons age 65 and over. Gateway II, started originally as a demonstration program in four counties of Maryland in 1982, and is being expanded to a statewide program. Its purpose is to help older persons, at risk of institutionalization, to remain in their own homes if that is their wish. The services of Gateway II includes a comprehensive assessment of the needs of the older individuals, a case manager to work with the person and their family to secure and coordinate services, and a pool of so-called "gapfilling" funds to be used for low-income persons when needed services are not available from other sources. The program includes an "income and resources" test feature of the program, e.g. 80% of the state's median income and an assets limit of $11,000 for an individual and $14,000 per couple.

Conclusion

Mr. Chairman and members, it seems to me that there is even a more compelling need for the Older Americans Act now than there was 22 years ago when Mr. Fogarty and Senator McNamara, and others in the Congress, had the vision to enact the original law. We are fast approaching what has been termed by many as the Aging

Society. It will be a society where one out of every five Americans will be an older person. It will be one which will have a profound impact on every social and economic institution in the country. It will be one that will include an older population that will be multi-generational, involving simultaneously an increase of health, vigorous, and talented individuals as well as an increase of those, who because of advance age, will have some moderate or severe functional impairments. It will increasingly be a population that will be living longer since future gains in life expectance can be anticipated.

I think the nation is in a better position to meet the challenges of the Aging Society because of the basic social policy decisions made in the area of aging over the last twenty-five years or so. The improvements made in the Social Security benefit program during that period, the enactment of Medicare, the passage of the Older Americans Act, the Age Discrimination Acts of 1967 and 1978, the creation of a National Institute on Aging in 1974, and other legislation that could be cited, are to the credit of those members of the Congress, from both sides of the aisle, who helped shape them and voted for them over the years.

I respectfully urge you to reauthorize the Older Americans Act in ways that you believe will strengthen and expand the provisions of titles III, IV, V, and VI of the Act.

With regards to the Title III, I urge you to continue the seperate authorizations for senior centers and supportive services, the congregate meals nutrition programs, and the home-delivered meals program. I hope that you may wish to place additional emphasis on increasing the availability of in-home services under the Title III program that will enable older people to remain living in their own homes or in non-institutional settings to the greatest extent possible. I also hope you will look favorably on proposals that may be made to give State and area agencies a greater role in the development of community-based long-term care services.

With regards to Title IV, I request that you continue the authorizations for research, development, and training grants. These discretionary grants are especially important for the Commissioner on Aging to have at her disposal to provide thoughtful national leadership. In the training area, there remains a compelling need for more trained personnel in the field of aging, especially health and social service personnel. In addition, in my opinion, a large scale program of continuing education is needed in many fields to enable practioneers to keep up with the new information and many changes taking place in their respective disciplines and profession with regards to the areas of geriatrics and gerontology. I particularly wish to commend the AoA for its recent efforts for the support of model training and continuing education programs for people working in such settings as adult day care, respite care, and in-home services.

I also urge continuation and expansion of the Title V and Title VI programs. The Title V program has a long and successful history of providing employment opportunities for low-income older people in a number of important human services settings. Title VI assures that there will be funds for planning and services made directly available to native Americans who reside on tribal reservations.

Finally, I urge you to reaffirm the importance of the Older Americans Personal Health and Education program authorized under Title VII of the 1984 amendments to the Act. The title's goal is still valid: a major preventive health services and education program aimed at helping older people better understand such basic health problems and as arteriosclerosis, arthritis, Alzheimer's Disease, hypertension, and diminished hearing and eyesight.

Thank you again for inviting me here. I would be glad to respond to any questions, or provide additional information, on the various points covered in my testimony.

Mr. KILDEE. Thank you, Mr. Bechill. I thank you for your testimony and I particularly enjoyed your comments on Senator Patrick McNamara, who is one of my mentors also. Occasionally, when I get down to Detroit, which is about 70 miles away from my home, I drive by the building named in his behalf. That is only a physical monument to him, he has left so many other monuments that touch the peoples' lives in such a very meaningful way. I can recall when I received news of his death and we were stricken by that and recall that he was so well thought of that the President of the United States himself came to Detroit to attend his funeral with all of his other friends there. He was a person who had a great sensitivity to people—came from a background that was sometimes rough and raw. But in that roughness and rawness, he had a certain deep sensitivity which was really a great asset to this country.

Mr. BECHILL. Yes, he did. I grew up in Detroit and I know of Senator McNamara and I know he was very active in many community programs before he was even elected to the Senate. He had a very good reputation with the people in the field of health and welfare, generally.

Mr. KILDEE. Very much so.

Professor, the President's 1988 budget requests a single generic appropriation for all Office of Human Development Service programs. This would give the OHDS the discretion to distribute funds for various programs as they see fit.

What would the effect of such a generic appropriation be upon these programs?

Mr. BECHILL. Well, I think it would blur them and it would—I think it would be very hard to predict the effect because, as I understand that type of process, it would be like a mega-approach to mega-block grant. In other words, it would give to the states and localities the full discretion of how to not only spend money in this broad area of human services but also give them carte blanche authority to transfer funds from one program to another.

I think that would thereby thwart the intent and objectives of several Acts of the Congress. I do not see how you could maintain any legitimate control over the various mandates, not only of the Older Americans Act but other Acts would be affected by such a generic process. At least, that is my impression at the moment.

Mr. KILDEE. The President, of course, couples fusing these appropriations together, with a $69 million dollar cut in total funding which would compound the problem. I think advocacy is extremely important, too, and very often you can lose some advocacy when you fuse things together in that fashion.

But I worry about not only the fusion but also the lessening of dollars in that. When you take all the programs that he would agregate into that, there would be $69 million less.

You have been in this field for many years, you are one of the—as young as you are—one of the real pioneers of this program.

Mr. BECHILL. Thank you.

Mr. KILDEE. Do you think the problems facing the elderly today are much different than those problems that prompted the enactment of the Older Americans Act in the first place?

Mr. BECHILL. Well, I think there is some difference occasioned by the fact that there are so many people in the older population living to a very old age, in particular, the population groups 75 to 84 and 85 and over. I think that is a change from the time that the Older Americans Act was enacted. And I think this is something that has to be recognized by the Older Americans Act and other programs whose services benefit older people.

One of the strengths of the Older Americans Act has been, I think, over the years, that it has been a very adaptable and flexible kind of program. Part of that is that it has to take into account the changing circumstances within the older population as well as the changing demography within the older population—a lot of which has to do with the increase in the numbers of persons over 75 and over 85.

Mr. **Kildee**. In the last few years, we have seen the emergence of what is called the DRGs, diagnostic related groups in Medicare where people are put out of hospitals, and this is often said, quicker and sicker. How does that change the role of, and the purpose of, these programs that we have under the Older Americans Act?

Mr. **Bechill**. Well the DRG system is a system that is generating a lot of pressure on agencies in the community. I am responsible for the development on our campus, at the request of the Chancellor, of a case management program and the expansion of what we are doing in case management education and training in the various professional schools.

And so, I come in contact with a lot of the departments of medical social work at the various hospitals who are taking, along with the nurses and physicians, the brunt of the responsibility for this planning. People are being discharged earlier and there is some evidence to suggest that they are being discharged sometimes without proper planning, but that is being looked at, I know, by the Congress. But I think to answer your question, I think the pressure of the DRG system is that it is generating more pressure on in-home kinds of services. Other words, when that 81 or 82-year-old person has to leave that acute care hospital, there has got to be services made available for that person in the home.

And right now, the discharge planning in the hospitals under Medicare begins day one. So there are lots of pros and cons associated with the DRG system. But one of the things that it is doing is placing a very heavy demand on in-home service agencies. And I think if you went out and talked with any community, small or large, they would report that that is the case.

Mr. **Kildee**. It would seem that if the purpose of the DRG, is to save Medicare dollars, then the government that has made that decision should at least put some dollars into probably less costly in-home services. For example, the case I used earlier, the Meals-on-Wheels—that if a person is discharged earlier with the purpose of saving some costly hospital costs and they are put back in their home earlier, then it would seem that both morally and perhaps fiscally they are saving dollars here that they should put dollars over there to increase the availability of a program like Meals-on-Wheels or of visitations.

Mr. **Bechill**. Well, I would agree and I think what we have now—and it is developed over a long period of time—we have a very severe imbalance between institutionally based and non-institutional community based services. Now, what has contributed to that to a large degree has been the fact that the authorizations for Medicare and Medicaid over the years have emphasized institutional based services. So, there is an imbalance and that imbalance has to be looked at and I think addressed in a way that would probably—and I really do not want to pretend that I know all the answers here because this is a difficult, difficult area—but in some way, I think what the strategy that I see now following is an effort by the Congress to try and contain some of the institutional costs, particularly those associated with hospital care and look at ways that possibly we could increase the out-of-hospital services, the services that would help older people in their homes.

Mr. KILDEE. And assume if we do one, if there is an attempt to save cost over here at the more expensive programs, that we should then both morally and fiscally say "let us put some money over there, then."

Very often in government, the right hand does something the left hand does not fill in. And that is what I have seen. I have seen pressure put on agencies in various areas around the country, pressure because they have a greater service population because of people being put out of hospitals or there is greater demand on their services. Yet, very often, the increase of their finances did not match the increase for the demand for services.

Mr. BECHILL. Well, I think along these lines, I think there are many, many places in the United States where there are waiting lists for services. I have the responsibility, legal and otherwise, for care of an aunt in Michigan who is 83 and I know firsthand what are some of the problems in attempting to get services for her in the home, particularly when she was being discharged from the hospital on a couple of occasions.

There are waiting lists in Michigan, there are waiting lists in Wayne County, there are waiting lists in affluent Oakland County for a lot of these services. You cannot get them immediately, you cannot get the Meals-on-Wheels. It takes, often, 30, 45, 60 days. The in-home services are there in name but they are not immediately available.

Mr. KILDEE. Thank you very much.

Mr. Tauke?

Mr. TAUKE. Thank you, Mr. Chairman.

Professor Bechill, first of all, I want to thank you for giving us something of an historical perspective. So often around here we lose that, and it is good to begin our hearing that way.

This is a rather mundane question but it is one that we have to face. What should the length of the authorization be, in your judgment, and can you briefly give us, from your perspective, the pros and the cons of a longer versus a shorter reauthorization period?

Mr. BECHILL. Well, as a former bureaucrat, I always favor the longest authorization possible because frankly I am very nervous, today—I do not enjoy coming up before committees and having to justify programs every two or three years. I do think that one of the advantages in having an authorization period, let us say, that has the pattern three years that we follow, and it does give the Congress some opportunity to review, particularly if they sense that there are a lot of things that need to be changed or that there are some serious problems under this particular legislation that are not being addressed.

I notice that Mr. Kildee's bill is for a four-year authorization. I would say that would be an appropriate time period because this Act has 22 years of history. It is not as if, you know, it is a new venture for the Federal Government. I would think that, from that standpoint, either a three or a four-year authorization would be quite in order. Five might be too long for the Congress, for the Members of the House, for the Members of the Senate.

Mr. TAUKE. There has been quite a bit of concern about the structure of the Administration on Aging, where it should fit into the department. You touched on that issue, you did not speak to it directly. How do you think the Administration on Aging should be structured? Should it be changed from what it is at the current time and where should it be within the department?

Mr. BECHILL. Well, the organizational location of the Administration on Aging has always been a controversial matter. I think it should be an independent agency. I think the Commissioner on Aging should have direct access to the Secretary of Health and Human Services.

The history of the organizational location of the Administration on Aging has been sort of up and down. But I also have to say this—that I do believe that the Commissioner on Aging needs to have considerable resources at her or his disposal to do this broad job that is required under the mandates in the Older Americans Act. And I do not think that that has been always the case. In other words, I think that often times, the Administration on Aging has been short handed, under staffed in terms of their particular mandate.

Mr. TAUKE. That is not the case now, in your view?

Mr. BECHILL. That is my view——

Mr. TAUKE. Do you think now that Carol Fraser Fisk has direct access to the Secretary?

Mr. BECHILL. I think that would help, and I have——

Mr. TAUKE. Do you think she has it now?

Mr. BECHILL. Do I think she has it——

Mr. TAUKE. Yes.

Mr. BECHILL. Now? No.

Mr. TAUKE. One of the challenges for this Congress is to ensure that services are distributed in a comprehensive way, complete way across the nation. At the current time, in your view, do we have an uneven distribution of services or, putting it another way, do we have pockets of the nation that are poorly served?

Mr. BECHILL. I have——

Mr. TAUKE. Either geographically or maybe population groups—you alluded, for example, to the——

Mr. BECHILL. All right, all right, I see——

Mr. TAUKE. To the minority population.

Mr. BECHILL. Yes, well—there are a couple of thoughts that I have. First of all, there is a considerable amount of interstate migration of older people. And I would wonder, for example, if the formula really keeps up with what really is happening in terms of the migration of older people into a state like, for example, Florida. That is a very extreme situation with the older population there—

is growing very, very rapidly, much more than I think people had anticipated even five or six years ago.

The minority aging population of the United States is really a very heterogeneous population. And it may very well be that it is under-served somewhat because of the way that the funds are distributed, because, for example, the hispanic elderly population, is largely concentrated in six or seven states—Illinois, New York, California, New Mexico, Texas, Arizona, Colorado. From that standpoint I think people representing the minority organizations may have some concern.

Mr. **Tauke**. Do you think we are not serving them well? Is that a problem with the legislation? Is there a change we should——

Mr. **Bechill**. No, I——

Mr. **Tauke**. Do we have inadequate outreach? Is it poor administration?

Mr. **Bechill**. I think it could be a combination of factors and I really do not think it is one factor only. I know that I have a lot of respect, very great respect for Carol Fraser Fisk. Ms. Fisk is the Commissioner on Aging, and I know that she is concerned with this decline. I know that the state agencies are concerned with the decline. They are looking at it, but I think it is something that I do not think people can point their finger and say one factor is contributing. There may be several.

Mr. **Tauke**. There are a lot of things I could ask you about, but let me just ask one other thing. I know my time is expiring, but—you indicated you would like to see more money for Title IV, the research area.

Mr. **Bechill**. Yes, yes—and training.

Mr. **Tauke**. Research and training.

Mr. **Bechill**. And training—you cannot let a professor come in without talking about education and training.

Mr. **Tauke**. Let me focus a moment on the research part of that. How should the research moneys be distributed, in your view? Should that be solely at the discretion of the Commissioner?

Mr. **Bechill**. Yes, I believe so. I think it is the only immediate funds that are available to the Commissioner where they have their discretionary funds—I think, over the years, they have been the source of new ideas and innovations. I think they have been well handled, by and large.

Mr. **Tauke**. Is it the Secretary who should determine what the subject matter should be for the research?

Mr. **Bechill**. The Secretary of Health and Human Services?

Mr. **Tauke**. I mean the Commissioner.

Mr. **Bechill**. Yes, I believe so.

Mr. **Tauke**. Okay. I have a little difficulty, I guess, with that. And I do not want to make a mistake—I know that it is difficult for Congress to see into next month much less look three, four years down the road. But, I wonder if it is not appropriate for Congress to give some direction to the research?

Mr. **Bechill**. Oh, I—excuse me—I thought you meant from an administrative standpoint.

Mr. **Tauke**. No.

Mr. Bechill. I have no problem with that. As a matter of fact, Congress has done this with respect to the research and development authority over the years.

Mr. Tauke. Yes, I know.

Mr. Bechill. Back when I was Commissioner, we had——

Mr. Tauke. And you do not have difficulty with that? I thought from some of the comments——

Mr. Bechill. No, I am sorry, I am sorry——

Mr. Tauke. You were suggesting that——

Mr. Bechill. No, I did not mean to suggest that, no, because I think that has always been the case—Congress has mandated certain areas that need attention under research and developmental approaches.

Mr. Tauke. And from your perspective, the awarding of that money has been handled in an appropriate way; there are not any problems.

Mr. Bechill. I think on balance it has been handled well, yes.

Mr. Tauke. Thank you. Thank you, Mr. Chairman.

Mr. Kildee. Thank you. Mr. Biaggi?

Mr. Biaggi. Thank you, Mr. Chairman.

Welcome, again, professor.

Mr. Bechill. Thank you.

Mr. Biaggi. All the—Chairman Kildee made reference to your long-time contribution and I must add my comments in that regard, too. You have been outstanding, responsive, and have never lost your sensitivity and always been made available—always made yourself available for these hearings, and we are greatful to you for it.

Question—well, someone asked why four years, you responded the longer the better but not too long. It might well be that four years could be very timely, because in 1991, we have the White House Conference on Aging. So, who knows what will develop out of that. Certainly, the focus will be more accute at that point.

Another question was asked that—I think the chairman asked you a question about the generic approach, generic funding with relation to Title III and you said that would kind of blur things. There is no question it would. It is another word for block-granting and we have opposed block-granting especially in relation to nutrition. We have fought to categorize that separately over the years and will remain adament in that position—especially when you regard the fact that 46 percent of the whole area of the funding is nutrition. And a rose is a rose is a rose no matter what name they give you, it is something that we should be wary of.

But from your historical and current perspective on the issue of targeting, can we in fact improve the laws mandating to reach the elderly in the greatest economic and social need under existing language or must we go beyond that? Because somehow, we are not reaching as far out as successfully as we should, especially with relation to the minorities.

Mr. Bechill. Well, I will be frank, I have nothing to lose on this. I am not so inclined to put another mandate in the Act. I think the major thing is to improve the programming, to really look at what it is about the performance of the aging network that is contributing to this decline. If you want to put statutory language in, that further earmarking of money, which I know you are proposing and others are proposing, that may or may not, Mr. Biaggi, result in what you are trying to achieve. I think that the committee needs to look and get as much information as it can about what is contributing to the decline and if it is—if it can be corrected by an earmarking approach, maybe that is the way to go.

My instincts tell me that other things are happening here.

Mr. BIAGGI. I have a feeling——

Mr. BECHILL. Yes.

Mr. BIAGGI. That we have been in business—being in business for a long time, the network has been established, everything—the whole mechanism is in place.

Mr. BECHILL. Yes.

Mr. BIAGGI. And we know a lot of people are dedicated and working out there. But there is a—is there a—some lethargy taking hold in this outreach operation? Are people comfortable out there and working just what they have and are not really going out with the vigor that they may have had at the outset?

Mr. BECHILL. I can only speak for the state of Maryland and I do know of a lot of the area agencies staff and people in the state of Maryland. I do not think they are comfortable. I think they feel, however, a little overburdened, from this standpoint. The older population is increasing, the demands coming into the state and particularly the area agencies are increasing, and they often times do not see a commensurate increase in resources, either added federal dollars or added state and local dollars.

So I do not think there is, at least in Maryland, I do not think there is apathy. That is not to say that maybe we do need to look at some new outreach approaches, some training efforts to increase the sensitivity of people working in the networds to the particular needs of the minority aging. I think we need to look particularly at the staffing patterns in state area agencies with respect to whether or not they have minority staff as part of their program in sufficient numbers to have this kinds of sensitivity.

Mr. BIAGGI. I know outreach is one phase of it. Tell me about means testing. I think I anticipate your answer, but I would like it for the record—with relation to targeting.

We will always have the problem of insufficient funds and—where it is trying to cover the entire panoply of programs and concerns, and yet the moneys are never commensurate with the increased mandate. Means testing seems to become more and more appealing to some. What is your attitude toward that?

Mr. BECHILL. Well, I can understand why it is being considered, given the present fiscal environment; but I am very much opposed to the idea, as I indicated in my testimony, of interjecting an income or a means test into the Older Americans Act program.

I think it would change the perception of the program that is held by a number of older people and I think it would contribute very much, as other means tested programs do, to a feeling of stigma on the part of those people that are the beneficiaries of that program. And I think that this is a very important decision for you to make.

I think if you go down the means testing road or the income testing road, it will be a major departure for the Older Americans Act and the philosophy, I think, that went into the original Act. I remember particular discussions I had not just with Congressman Fogarty but with many other members of the Congress—John Dent of Pennsylvania, John Brademas, Mel Laird, I could mention a number of people and I know the history of this.

Of course, this is 1987, but I do not think the situation has changed. I think you would find the organizations representing older people strongly opposed by the introduction of a means test.

Mr. **Biaggi**. If we had means testing, do you believe it would result in decline in participation?

Mr. **Bechill**. It could, it could in some respects. I think this program is, I need not tell you, Mr. Biaggi, perceived very favorably by most older people who know about the program and who have participated in the program. And I think one of the reasons that it is perceived that way is that it is not perceived as a traditional welfare program.

Mr. **Kildee**. On that point, if I may, Mr. Biaggi.

Mr. **Biaggi**. Go ahead.

Mr. **Kildee**. I think it is perceived well not only by the direct recipients, the older people, but very often by those who love them very much and really are not in a situation themselves to give the type of service that person needs. I think it is a program, I am certain Mr. Biaggi and I have seen this many times, where it has a large degree of acceptance and support beyond those who even are the direct recipients.

Mr. **Biaggi**. I have one more question. I thank the chairman for indulging me.

On the issue of eligibility in Title III—we are—there are a number of proposals being offered. One is to lower the eligibility age to 55 and another is in effect to raise it to 70 through a change in the formula. What is your reaction to raising the age of eligibility?

Mr. **Bechill**. Well, the original Act, set the age at 65, in the formula. I would not support lowering the age requirement to 55. I think 60 is a fair age.

I think if you increase the formula to age 70, that is more of a profound change than you realize at first, because what you are literally saying is you are not going to be concerned with a rather important period leading up to age 70, where people are moving from full-time work into full-time retirement. And that has always been a very important period for people.

I do not know the statistics on this, but my guess tells me that if you move the formula to age 70, that it would have some interesting effects in terms of the distribution among the individual states. And I, Mr. Biaggi, do not know what the effect would be.

Mr. **Biaggi**. Thank you, professor. Thank you, Mr. Chairman.

Mr. **Kildee**. Mr. Grandy?

Mr. **Grandy**. Thank you, Mr. Chairman.

Professor Bechill, I wanted to talk to you a little bit about Alzheimer's disease and what the reauthorization of this pact can do, assuming of course that there is going to be a greater density of elderly in the years to come. There is probably going to be a greater proliferation of Alzheimer's disease. I am curious because, as I understand this Act, we have at least two titles that would probably be studying the disease and disease support services. I notice in your testimony that you suggested that we need funding for Title VII, major preventative health services education program aimed at helping older people better understand such basic health problems as Alzheimer's disease.

What is entailed here? What do you see, assuming that we funded those provisions—happening under that title? What do you think would be a good Alzheimer's disease program?

Mr. **Bechill**. Well, I think the aim of that Title VII program, as I understood it, was to provide broad basic health education information to people about various health problems. I have not talked this out with regards to Alzheimer's disease, but there is a lot of fear about it, and I think the older population would benefit from having objective information about Alzheimer's disease.

Sometimes we are putting the label of having Alzheimer's disease on a person when they do not. So I think from that standpoint, you have a preventative type of approach that I thought was built into Title VII.

Now in terms of the kinds of services needed by people with Alzheimer's, I think that is another matter. I think that means looking at what kinds of support services can be given, particularly to the families of individuals who have Alzheimer's disease as well as to the individual who has Alzheimer's.

One service, for example, that is under supply and it would be a wonderful service if it could be provided throughout the United States on a large scale, would be respite care, just so that the individual's caring for the person with Alzheimer's disease would have the opportunity now and then to take a weekend or to be relieved of that pressure.

Mr. **Grandy**. Do you see that as being under Title VII as opposed to Title IV, which would be grant projects. Is that correct?

Mr. **Bechill**. Respite care can now be funded under Title III-B.

Mr. **Grandy**. I am trying to figure out where, without duplicating services, the best place to focus our attention in this Act.

Mr. **Bechill**. On the education component—I would put it into something like Title VII. But on the services side, I would put it into the Title III-B program relating to supportive services.

Mr. **Grandy**. I understand Senator Metzenbaum has proposed the creation of a new title to authorize $80 million between now and 1992—allocate to the states' funds for providing a wide array of home and community based services for persons with Alzheimers and similar diseases. The federal share would range from 60 to 80 percent with states required to give priority to persons 60 years or over and to those who are the neediest.

Under what you have just layed out, do you see the need for a Title VIII or are we duplicating services there?

Mr. **Bechill**. Well, I do not—I do have a copy of the Metzenbaum bill, it was shared with me, and I do know of his interest in it. I would rather not say do we need a new title. Again, here is a situation where this is a major problem that is not going to, as you put it, it is going to increase and as I understand the force of Senator Metzenbaum's proposal, he feels that there is a large package of funds that is needed right now to make a dent and make an impact in this area.

I guess I have to be candid. I am not arguing at the moment for a new title for Alzheimer's but I would say if the Congress wants to put additional money and wants to put additional emphasis, new language, I think it is a reflection of how serious a problem this is.

Mr. GRANDY. Let's talk about the figures for a moment. Is $80 million, do you think, on the high side or the low side for what is needed over the next four or five years to focus on the Alzheimer problem, including disease support services, research projects, and so forth?

Mr. BECHILL. It would be a good start.

Mr. BIAGGI. Will the gentleman yield on that point?

Mr. GRANDY. Yes, I would be glad to yield.

Mr. BIAGGI. In my opening statement, I made reference to the fact that we are developing a Title III-B2, which would deal with Alzheimer's disease and I would think would respond to the gentleman's concern. The original language of the Alzheimer's was developed by this gentleman and I think III-B2 hopefully will be adopted by this committee and by the House. I think that there will eventually be a reconciliation between Senator Metzenbaum's proposal and ours. Thank you.

Mr. GRANDY. Thank you.

In my time remaining, then, I would like to ask you a little bit about what you did not mention in your remarks but is in your written testimony—your Gateway II program.

Mr. BECHILL. Yes.

Mr. GRANDY. In Maryland, the purpose of the Gateway II program is to help older persons at the risk of institutionalization to remain in their homes if that is their wish. Could you expand upon this a little bit? How is this working in Maryland?

Mr. BECHILL. Well, it was started out as a research and demonstration program or proposal recommended by Governor Hughes to the Legislature. It started out with four counties. It was expanded to nine and there is now in Governor Shaeffer's budget money so that it is extended to all jurisdictions of the state, including Baltimore city.

It involves, at the local jurisdictional level, an effort to coordinate the activities of three agencies at that level—the Area Agency on Aging, the local Health Department, the local Departments of Social Services—to try and identify people, the so-called frail elderly person, who is in need, who conceivably, without these services, would have to go into a nursing home.

Along with a Gateway II program, there is a sum of money that is distributed to each of these local jurisdictions which is called, in the Gateway II legislation in Maryland, gap-filling money and it is available to help pay for some of the services that may not be being provided by some of these other agencies—so that you have an effort at the local level to coordinate these three programs.

It has worked fairly well, it is a program that is limited, however, as I indicated in my testimony. There is an income and resource test in the Maryland program.

This is a program that is funded solely out of state funds, although it involves the area agencies on aging and the local health departments and the local departments of social services and their respective state counterparts, in this case the Maryland Office on

Aging, Maryland Department of Health and Mental Hygiene, and Maryland Department of Human Resources.

Mr. **Grandy**. Shall I assume because it is an entirely state funded project, that that is why you are allowing some kind of an income test there?

Mr. **Bechill**. It has an income test, but what I wanted to commend to you was the approach, because I think the approach is one that has—and I think other states have a somewhat similar effort where they are trying to—for that particular group in the older population, trying to work together more effectively, because I do think coordination of these programs and services always is an issue, as well, and has to be addressed.

Mr. **Grandy**. Thank you, Mr. Chairman.

Mr. **Kildee**. Mr. Solarz?

Mr. **Solarz**. Thank you very much. I think Mr. Visclosky was here ahead of me. If it is okay, I will yield to him.

Mr. **Kildee**. You are very kind. I am always choosing between seniority and time of arrival.

Mr. Visclosky?

Mr. **Visclosky**. As a great respecter of the seniority system, I express my deep appreciation to Mr. Solarz.

Mr. Chairman, thank you very much.

Professor, you did give a very well-thought-out historical context for the Act, and I appreciate that as a new member of the subcommittee.

There was a white paper that was published by a commission of the American Bar Association on the legal services component of the Act and I am wondering, for my background information, in which to place that in a context, could you elaborate a bit as far as the historical context of legal services under the Act or the purpose behind it and how you they have functioned in recent years?

Mr. **Bechill**. I think the legal services were authorized either in the 1973 or the 1975 Amendments. My memory should be better, but it is either in one of those two changes. So, the aging network has had an experience in legal services of some time.

They were given a great deal of emphasis during the tenure of Dr. Arthur Flemming when he was commissioner and later by Mr. Benedict. I think they have been very important services and the reason they have been very important is that often times they have been especially helpful to older people with legal problems that needed accurate information and help.

So, I am personally very supportive and enthusiastic about the legal services part of the program.

Mr. **Visclosky**. How does it relate to the Legal Services Administration?

Mr. **Bechill**. They are not a part of the Legal Services Administration. Generally speaking, the services are provided often through something like a legal aid bureau which may also have relationship to the Legal Services Administration, but they are designated in the various—as I understand them, in the various state and area agency plans for that purpose, in terms of legal services.

Mr. **Visclosky**. Professor, thank you.

Mr. **Kildee**. Mr. Solarz?

Mr. **Solarz**. Yes, thank you very much, Mr. Chairman.

Professor, have you any sense of the magnitude of the population eligible for the services provided for by the Older American Act in relationship to the number that are actually served by it, the various titles?

Mr. **Bechill.** No. I have to be honest with you, and this is one of the problems that the people administering the program face—trying to determine at any one point in time how many people may need and want to have these services.

Mr. **Solarz.** Do you know if anybody has this information?

Mr. **Bechill.** I think the people who are on top of it the most are people who are directly administering the program at the state and area agency level. They do make projections as to the numbers.

Mr. **Solarz.** Would it be a fair assumption that there are probably many more people who are theoretically eligible for participation in these programs than the programs actually serve?

Mr. **Bechill.** Yes, it would.

Mr. **Solarz.** I certainly have that impression. For example, in my district there are probably thousands of senior citizens who would like to participate in the senior citizens center programs but they cannot because there is no room for them.

Mr. **Bechill.** I am just saying that I have not seen the precise data as to numbers.

Mr. **Solarz.** Now, on the question of the means tests which came up a little bit earlier, do you have any idea as to how many people who currently participate in these programs would be obligated to drop out if there were a means test? A test presumably pegged to something around the poverty level. How many people who passed the means test who were below that level would therefore come into the program if you did have a means test?

Mr. **Bechill.** Well, if you tied the means test, let us say, to the poverty line, you would approximately be talking about a population of six out of every seven persons, let us say, age 65 and over, would be people above the poverty line.

I think the impact of the means test would really hit hard with regards to participation in the senior center programs. We have had a prior experience with trying to apply a means test under the Title XX program to a group facility like senior centers which was not too favorable. So, I would think that you would really be talking about that segment of the older population above the poverty line and that would be the population that would be at risk of possibly not wishing to participate.

Mr. **Solarz.** I gather from you response to Congressman Biaggi that you think there is a real possibility that if we did establish a means test for senior citizen center participation, for example, and pegged it at the poverty level, given the fact that six out of every seven seniors are above the poverty level, that substantially more seniors might be forced out of these programs than would be able to come into them because places would open up.

Mr. **Bechill.** Well, yes, perhaps, but it would really depend on how you administered the test and a lot of other factors. I really have to go back to my experience even before coming to Washington. In California, where I worked very closely with hundreds of senior citizen clubs in that state, and organizations, and I still know a lot of the people in a lot of the leadership out there—and I know that this would represent quite a change. I think it would be met with a great deal of distaste.

Mr. **Solarz**. Yes, well, I am not advocating it, but I think it is important to try to get answers to these questions.

I gather that there is some controversy over the question of the voluntary contributions which seniors make to the meal programs and I wonder if you have any idea how much of the cost of these programs are covered by the voluntary contributions. Also, do you think it is useful to permit centers to solicit them or whether they ought to be prohibited?

Mr. **Bechill**. I have always favored the voluntary contributions and I emphasize the word voluntary. They do represent an important source of funding. I can tell you—just my experience in Baltimore city—that the voluntary contributions into what we call the eating together program, are very substantial. I think they approximate about $1 million, annually. That is just for the city of Baltimore.

Mr. **Solarz**. I suppose the bottom line is that as a result of the voluntary contributions, there are substantially more meals that are served than you would have without it, unless we were prepared to make up the difference, which we probably would not be able to do. But even if we did make up the difference, given the fact that there are many more people that would like to participate than there are places, it would still ultimately reduce the number of meals that could presumably be served since at any level the voluntary contributions provide more money for meals. Is that correct?

Mr. **Bechill**. Yes, I think so, and I think the idea of having voluntary contributions is at another strength—it has enabled an older person, if they want to, to make a contribution into the program. I see nothing wrong with that.

Mr. **Solarz**. Do you have the impression that the voluntary contributions are in fact voluntary throughout most of the country? Is there significant pressure brought on people to make contributions even if they do not feel they can?

Mr. **Bechill**. I know—I can only speak from my experience—I know of no feeling of duress or pressure, that I know of in Baltimore and the state of Maryland.

Mr. **Solarz**. Finally, in your testimony on page 10, you said that, "I hope that you may wish to place additional emphasis on increasing the availability of in-home services under the Title III program that will enable older people to remain living in their own homes or in non-institutional settings to the greatest extent possible."

How precisely would you suggest we do this, assuming we decided to follow your advise?

Mr. **Bechill**. Well, I think you can do this either by language in the Act that would give additional emphasis to this or——

Mr. **Solarz**. I am not sure what you mean by "additional emphasis".

Mr. **Bechill**. I am not suggesting a set-aside but I am suggesting, perhaps—in the history of the 1987 Amendments, the Congress can say we want under title III-B greater appropriations, greater priority to in-home services. And one way that that can be done, of course, is to increase the authorization also for Title III-B.

Mr. **Solarz**. Are you saying you certainly would like to see greater funding for III-B, but if for some reason that is not possible in terms of increasing the overall funding, you would like to see more of it relative to other parts of Title III than it now receives? Is that what you are saying?

Mr. **Bechill**. No, it really is not what I am saying. I do not want to see other parts of Title III hurt by that emphasis. In other words, this is part of the concern, I think. You have the home delivered, you have the nutrition meals, and I think you——

Mr. **Solarz**. But you are saying——

Mr. **Bechill**. Have a balance.

Mr. **Solarz**. But you are saying that of all of the programs funded by Title III, this would be at the top of your list in terms of any increase in funding that was available?

Mr. **Bechill**. That is my personal opinion, yes.

Mr. **Solarz**. Okay, and then you also said, "I also hope you will look favorably on proposals that may be made to give state and area agencies a greater role in the development of community-based long-term care services."

At what proposals? Specifically what did you have in mind here?

Mr. **Bechill**. Well, I think there is some language in the Act now with regards to community based long-term care and I was thinking, perhaps, of some of the ideas that I have heard with regards to giving more responsibility for case management kinds of services and give that kind of responsibility to both the state and the area agencies to perform. And I think that would be one thing that ought to be looked at very carefully.

Mr. **Solarz**. Okay, thank you very much, Mr. Chairman, thank you.

Mr. **Kildee**. Thank you, Mr. Solarz. And Mr. Bechill, we thank you. You have really helped both refresh our institutional memory of this program and point us to where we should be going in the future. We look forward to working with you as we go through the process of reauthorization. Thank you very much for your testimony.

Mr. **Bechill**. Thank you, Mr. Kildee.

Mr. **Kildee**. Our next panel will consist of Jill Duson, the Main Long Term Care Ombudsman, President of the National Association of State Long Term Care, Ombudsman Programs, in Augusta, Maine; Toby Felcher, Second Vice President, Association of Nutrition and Aging Service Program, Special Assistant to the Executive Director of the Baltimore City Commission on Aging Responsible for Nutrition and Services; Donna McDowell, Director of the Wisconsin Bureau of Aging, Chair of the National Association of State Units on Aging Public Policy Commission, from Madison, Wisconsin; and Russell Proffitt, Director of the Heritage Area Agency on Aging, National Association of Area Agencies on Aging, from Cedar Rapids, Iowa.

If you would come forward. You may proceed in the fashion that you were introduced.

Again, if you could summarize your testimony, your entire written testimony will be included as part of the written record of this hearing.

Whoever testifies first, please pull the microphone right close to you since they are not that sensitive.

Jill, did you wish to begin?

STATEMENT OF JILL DUSON, MAINE LONG TERM CARE OMBUDSMAN AND PRESIDENT, NATIONAL ASSOCIATION OF STATE LONG TERM CARE OMBUDSMAN PROGRAMS, AUGUSTA, ME

Ms. Duson. Yes, good morning, Mr. Chairman, members of the committee.

My name is Jill Duson, I am the State Long Term Care Ombudsman at the Maine Committee on Aging, and I am President of the National Association of State Long Term Care Ombudsman Programs.

I would like to summarize my comments and start with a brief historical background for the inclusion of the Ombudsman Program in the Older Americans Act.

The Ombudsman Program was initiated in June of 1972 with the granting of seven demonstration projects to improve the quality of care in nursing homes. Based on the success of those demonstration projects, the 1975 Amendments to the Older Americans Act gave the Commissioner on Aging power to make demonstration grants to states to develop Ombudsman Programs.

In 1978, the Amendments to the Act included a mandate that all state units on aging operate a Long Term Care Ombudsman Program. And finally, in 1981, the Act included a broader definition of long-term care facility which had the Ombudsman Programs expand their jurisdiction to include coverage of boarding home and adult foster care residents.

The Ombudsman Association is very grateful for the attention that has been devoted to our program both in the 99th Congress and in this Congress. This attention has come not only from Members of the Congress and Senate but also from a number of national aging organizations, including NASUA—the National Association of State Units on Aging and N4A.

I think that there has been a unique consensus amongst these aging organizations on the concept of strengthening the operations of ombudsman programs and what I would like to direct my comments to is kind of wish list of proposals that were made in the last session and have been made by a variety of other entities which ombudsmen have reviewed and would just love to have mentioned in the reauthorization of the Older Americans Act.

Firstly, we support the creation of a Title III-B within the Act which would require the operation of an Office of the State Long Term Care Ombudsman. This proposal would provide an identity to the program and clarify the functions of the program staff in the context of other state units on aging activities. This title should establish a set of core rights, duties, and protections which extend to the operations of that office and its designees.

Key amongst those powers that would be needed by the office is the simple power to officially designate local programs and volunteers to act as representatives of the office. From that designation, we hope would flow some specific provisions including protection from liability for good faith performance of duties, whistle blower protection for folks who complain to the ombudsman program or cooperate with investigations conducted by the program, access to legal counsel for the program staff and its representatives who may be subject to suit based on carrying out their duties, and conflict of interest restrictions on the entity which would designate the State Long Term Care Ombudsman, and also on the—on the—is that me?

Mr. **Kildee**. No, your microphone is okay. That is just a notice that session will start in 15 minutes.

Ms. **Duson**. Let us make this quick.

Finally, conflict of interest restrictions both on the entity which designates the State Long Term Care Ombudsman and the State Long Term Care Ombudsman's designation of volunteers and local programs.

One other thing—two other things I skipped, I guess, is clear access for the program to long-term care facilities that it covers, access to resident records with resident permission, and access to the investigative reports and survey documents produced by other state agencies relating to long-term care services.

Finally, ombudsmen feel it is really necessary to clarify exemption for our program from OMB Circular A-122 which includes specific anti-lobbying restrictions. The Act requires ombudsman programs to participate in the regulatory and legislative process at both the state and federal levels and so that clarity on this issue within the Act would help remove some of the chilling affect of the A-122 language.

There are about a handful of State Long Term Care Ombudsman Programs currently servicing consumers of home-care services. That handful includes the state of Maine. Clearly, consumers of home-care services need an independent advocacy system. We feel it is premature, however, to resolve the structure of that system by a national mandate at this time. In the alternative, we recommend that the committee consider providing demonstration funding for development of model home-care advocacy systems at the state levels and commission a national study to review and evaluate these demonstration programs and to develop recommendations for national implementation of a home-care advocacy system.

On training needs of ombudsmen, we strongly support the recommendations that the Commissioner on Aging, be elevated within the Health and Human Services Department specific to the ombudsman program. We feel there really needs to be support for the national ombudsman training program which will not only provide ongoing training for existing ombudsmen but provide—excuse me—orientation for new ombudsmen. And the Administration on Aging should have sufficient funding to carry out a national clearing house function which has sometimes been fairly strong from a national level and other times been fairly weak. It has been a circular process, apparently.

On funding issues, I would rap up by going back to the Title III-D recommendation. Ombudsmen have reviewed the recommendations of the Institute of Medicine. Those recommendations included a number of the Amendments to the Older American Act which I have mentioned. Included amongst those was the establishment of the program under a separate title, increased program funding, increase in the base funding from one percent of Title III–B or 20,000 to a base funding of 100,000, exemption from A–122, and most importantly the Institute of Medicine report recommended that the Secretary of Health and Human Services direct the Administration on Aging to take steps to provide effective leadership to ombudsman programs and that priority be given to the establishment of a national resource center for our operations.

I would be happy to answer any questions which you might have.

Mr. KILDEE. Thank you very much.

[Prepared statement of Jill Duson follows:]

PREPARED STATEMENT OF JILL C. DUSON, PRESIDENT, NATIONAL ASSOCIATION OF STATE LONG-TERM CARE OMBUDSMAN PROGRAMS

I am Jill Duson, State Ombudsman for the Maine Committee on Aging, Long Term Care Ombudsman Program, and President of the National Association of State Long Term Care Ombudsman Programs (NASOP). I am pleased to present the comments of the Association on issues relating to the reauthorization of the Older Americans Act.

The NASOP provides information, assistance, and professional development support to its members, the 52 State Long Term Care Ombudsman Programs. The Association provides a national voice for ombudsman participation in the development of public policy relating to the needs of long term care consumers. In addition, the Association provides a channel for involvement in national efforts to strengthen the capacity of the ombudsman/advocacy system.

Since its incorporation into the Older Americans Act (OAA) in 1978, the State Long Term Care Ombudsman Programs have become an integral component of the advocacy responsibilities of the state units on aging. The 1978 amendments, required the designation of a person to operate the Ombudsman Program and specified four broad mandates for program activities:

i. Complaint Handling
ii. Legislative Advocacy
iii. Administrative Advocacy
iv. Volunteer Training and Citizen Involvement

As the 10th anniversary of the incorporation of the program into the act approaches, Ombudsman welcome the attention which individual Congressmen, various Congressional Committees, and the network of interested National Organizations have focused on a review of program structure and the development of proposals to strengthen program effectiveness. Our membership is particularly pleased to have this opportunity to discuss proposed amendments to those portions of the Act which relate to the Ombudsman Programs with the Congressional committee responsible for reauthorization.

NASOP

SUMMARY OF COMMENTS--OLDER AMERICANS ACT REAUTHORIZATION

I. Operation of the LTC Ombudsman Program

NASOP supports the creation of a **Title III-D** requiring operation of an **Office of the State Long Term Care Ombudsman**.
The Title should:

- establish core rights, duties, and protections which extend to the operations of the "office" and its designees.
- require procedures to ensure access to facilities, residents and resident records, and state agency records.
- provide a clear exemption of the Office from A122 restrictions.

II. Advocacy for Home Care Consumers

A handful of Ombudsprograms have expanded to cover home care consumers through state action. It is premature to address home care quality assurance by national mandate. Instead, NASOP recommends that the Act be amended to:

- provide demonstration funding for development of model home care advocacy systems and
- commission a national study to review/evaluate program models and develop recommendations for national policy.

III. Training needs of Ombudsman

Funds should be provided to the Administration on Aging to:

- support a National Ombudsman Training Program and to provide orientation for new ombudsman.
- establish a carry out a national clearinghouse function to support ombudsman programs.

IV. Funding Issues

Ombudsman programs need an appropriation to increase base funding levels to $100,000 (under a new Title III-D or within the current Title III-B) with additional funds available based on a specific formula. NASOP recommends that:

- adoption of a Title III-D include **hold harmless** language to protect against loss of current state and federal funds.
- in the absence of additional funding, substantive amendments which do not require new monies should take effect upon reauthorization.

State LTC Ombudsman and program staff reviewed proposed changes to the Older Americans Act at the October '86 Membership Meeting of the Association. As a follow-up to that review, state Ombudsprograms have responded to a ranking form distributed by the Association in January '87. The following comments are offered on behalf of the national network of State Long Term Care Ombudsman Programs.

I. Operation of a the Long Term Care Ombudsman Program

Section III-B of the OAA requires the SUA to develop a uniquely identifiable entity: the State Long Term Care Ombudsman Program. It also requires the designation of a specific individual to carry out mandated program responsibilities. As is the case with many OAA programs, however, the Act leaves to the states a great deal of discretion in the actual design and operation of the Ombudsman Program. The flexibility reserved to the states has resulted in a variety of program models each of which is uniquely suited to local realities and needs. State Ombudsman believe that there are ways to strengthen the capacity and effectiveness of ombudsman programs in responding to the concerns of long term care consumers, without damaging individual state flexibility.

We urge your consideration of the following proposals which seek to establish a universal set of specific program powers and duties.

A. Placement of the SLTCOP's in a Separate Title

We support the creation of a Title III Part D requiring each state to operate, either directly or by contract, an **Office of the State Long Term Care Ombudsman**. In concert with this change, the Act should provide a matrix of specific powers and duties for the ombudsman programs. We support the separate title proposal as a means of establishing core functions for program operation and against which program performance can be measured.

OAA assignment of ombudsman program functions to an "office" within the state unit on aging (or other entity operating the program) would provide a context within which specific program operation needs may be addressed. Paramount among these needs is the ability to formally **designate** local programs and individual volunteers to act as **representatives of the "office."** This clarification of program status will establish an umbrella entity from which additional federal OAA protections may flow to the operations of the office, and its designees. The specific protections which State Ombudsman feel are critical to strengthening the ability of the program to operate include:

1. **protection from liability** for the program and its designees while engaged in the good faith performance of official duties.

2. "**whistle blower**" protection for individuals who report concerns or cooperate with investigations by the office.
3. penalty for interference investigations by the office.
4. provision of adequate legal counsel to any representative of the Office against whom suit is bought in connection with the performance of official duties.
5. specific **conflict of interest** restrictions on the entity which houses the Office and designation of representatives of the Office.

In addition, Ombudsmen strongly support language under the new title which would require establishment of procedures to **ensure access** by representatives of the office to:

...**facilities** (nursing and boarding homes and other treatment settings covered by the office)

...all **residents and resident records** held by the facility (with procedures to protect resident confidentiality) and;

...**records of agenciess** responsible for oversight of facilities or residents within the jurisdiction of the office.

Finally, Ombudsman support the proposals which would clarify that the activities of the Office shall be exempt from **the A-122 restrictions** on interaction with legislative entities. Ombudsmen have a responsibility under the Older Americans Act to monitor laws and regulations relating to long term care facilities, residents' rights and benefits, changes within the regulatory framework, and other areas impacting on the lives of residents.

Long term care consumers lack the resources to constructively put forward their concerns and ideas and effectively advance public policy objectives. The Ombudsprograms are excellent sources for identifying problems and pointing out positive and negative trends within the system. The Older Americans Act recognized this advocacy duty, and therefore, we believe that Circular A-122 does not apply to ombudsman programs. Application of the restrictions to the SLTCOP will force them to function as mere case work programs without the key element of using case experience to identify issues and advocate for systemic changes on behalf of these consumers.

Ombudsman have written letters to the Administration on Aging requesting clarification of Circular A-122 and its relationship to ombudsman programs. Our inquires were referred to OMB with no response in over two years. This inaction has had a chilling affect on some programs and has become an impediment to effective systemic advocacy.

Establishment of the "office" and requirements for specific core components within the Act, will ensure that individual state programs will have at their disposal the necessary tools to operate quality ombudsman/advocacy services. A collateral benefit of these changes will be to promote the development of management and professional performance standards against which program performance can be measured.

II. Advocacy for Consumers of Home Care Services

There have been a number of proposals to expand the duties of the Long Term Care Ombudsman into areas not associated with its' traditional activities of advocating on behalf of individuals residing in long term care facilities, specifically nursing homes and boarding care facilities. Many ombudsman respond to suggestions of expansion by pointing out the present inadequacies in funding for our traditional duties, particularly in the area of board and care facilities. We are motivated by a desire to insure that current advocacy responsibilities are not diluted by new federal mandates. Areas which have been suggested which might benefit from ombudsman intervention include: home health; hospitals or acute care in the areas of discharges and DRGs; the Veterans Administration homes; hospice, and LTC/Medigap Insurance. Due to increased attention from Congress and other Aging organizations to expand long term care ombudsman duties, ombudsman have worked to develop a clear position on program expansion.

A handful of state long term care ombudsman programs have entered into contracts or have been mandated by their states to engage in expanded activities particularly in the areas of home health and acute care. The ombudsman who are involved in these activities are developing strictly defined procedures or policies to insure that limited resources are not overtaxed. Other ombudsman have resolved cases involving home care and acute care on an individual basis. In these cases, we have taken on responsibilities in lieu of leaving a consumer with no source of help in dealing with their concerns.

Clearly, **consumers of home care services need an independent advocacy system**. It is premature however, to address this need with a broad brush assignment of home care quality assurance to the state units and area agencies. It is also premature however, to expand the long term care ombudsman program to cover this population.

In the alternative, NASOP recommends consideration of the following actions related to home care advocacy:

1. Provide funding for research, demonstration and training **grants** related to the development of model Home Care Advocacy Systems.
2. Commission a **national study** to review NLTCOPs which have expanded pursuant to state mandate, to assess impact on program financial, training, personnel resources; and impact on program activities on behalf of nursing and boarding home residents.

The study should be funded through the Administration on Aging and contracted out to an appropriate agency with a strong record of long term care involvement and commitment. The agency awarded the contract must involve the NASOP and /or other interested parties throughout the entire process via an advisory committee. The results of the study should be shared with Congress and the entire aging network before any federal action on expansion of the Ombudsman Program.

III. Training Needs of Ombudsman

Another key to providing nursing and boarding home residents with capable and competent ombudsman services, is assuring that ombudsman are informed about emerging long term care issues and trends impacting on residents, negative facility behavioral patterns and state responses to those patterns including laws and regulations. In addition, summary information on each state's ombudsman activities, resources developed, and special projects needs to be shared.

To meet these goals the Administration on Aging should develop, with ombudsman input, a national training program which includes an orientation program for new ombudsman and an ongoing training system to address emerging problems/issues identified throughout the various state programs. In addition to training, a national clearinghouse function must be established through which we can share information and identify helpful resources.

IV. Funding Issues

Current OAA minimum funding requirements of 1% of III-B funds or $20,000, whichever is greater, is insufficient to support service delivery to program clientele who make up over 5% of the elderly population. We recommend adoption of a funding formula which ensures that each office; (whether in a state unit on aging or free standing) can operate an adequate statewide program: a program with sufficient staff and resources to do the job. This formula should include a review of base funding requirements which have not been adjusted since 1978. Any new formula should consider elderly population statistics, the number of nursing and boarding care beds, geographic coverage and other factors. The Institute of Medicine study of long term care issues included several recommendations for strengthening the LTCOPs including provision of **a new base funding level of $100,000**. The NASOP recommends a base funding of at least $100,00 and urges the Committee to consider this figure in the context of the growth in numbers and care needs of the populations which we currently serve.

The Committee has been presented with two options. If the Committee opts for creation of a Title III-D to cover the Ombudsprograms, an increase of the base funding to $100,000 per program, with additional funds distributed in accordance with a specific formula must be considered.

In addition, it is important to add hold harmless language which will prevent the diversion of OAA funds currently committed to ombudsman activities. To fail to do so will seriously dilute the effect of any additional funds earmarked for the Ombudsprograms. Any appropriation for Title III-D should include the specific provision that funding to the SLTCOP may not be less then the expenditure levels currently in effect in the states.

If the Committee chooses to amend Title III-B, we urge you to increase the base funding to support activities under this section. A reexamination of the base funding in III-B is long over due. Many of the program operation concerns enumerated herein can be incorporated into either the existing section III-B or the New III-D.

In the absence of any new funding, the substantive amendments to the act which will not require additional funds e.g. access to facilities, records, records of state agencies, and immunity should take effect upon completion of the reauthorization. In addition, current language and levels of OAA funding to ombudsman services in the states should be specifically protected.

In conclusion, the status of the Ombudsprograms and the constituencies which we serve has drawn the special interest of concerned members of Congress. The expectations of Ombudsman, consumers, and community advocates have been heightened. We are confident that the reauthorization process will result in substantive improvements in the quality of care provided to consumers and the quality of advocacy on behalf of individual residents.

STATEMENT OF TOBY FELCHER, SECOND VICE PRESIDENT, ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS, SPECIAL ASSISTANT TO THE EXECUTIVE DIRECTOR OF BALTIMORE CITY COMMISSION ON AGING RESPONSIBLE FOR NUTRITION AND INSTITUTIONAL SERVICES, MARYLAND

Mr. Kildee. Toby, do you want to give your testimony?

Ms. Felcher. I am very pleased to be here today and on behalf of the Association, I want to thank you for this opportunity to present testimony on the reauthorization of the Older Americans Act.

Studies have demonstrated the effectiveness of nutrition programs in improving the quality and quantity of the lives of the elderly. The support for this clearly identified program is responsible for the success of the congregate meal program and the Act itself.

In general, NANASP is encouraging Congress to look at this reauthorization as a fine tuning of the Act rather than a major overhaul. We also believe in the need to maintain the varied levels of service that allow us to be responsive to the needs of our older clients at various points in the aging process.

The unique quality of the human services that are provided as part of the Older Americans Act is directly linked to the legislation's original dedication to maintaining independence, not creating dependence. And while we recognize the increasing need for services for the more frail home-bound seniors, we feel it is essential that we find a way to meet those needs without diminishing the strength of the community based congregate programs.

NANASP also maintains a firm position resistant to consolidation of the titles in the Act. It is our belief that the separate titles, authorizations and appropriations help maintain the identity of the programs and strengthen Congressional support.

Now here comes the biggee. We are the ones that propose at this time that the eligibility age for recipient services under the Older Americans Act be reduced from 60 to 55. NANASP members working at a direct service level recognize the need for greater targeting of services to minority participants. The current restriction of offering services to those persons 60 or older often eliminates minority persons needing access to our programs. The documented information related to the premature aging and shortened life expectancy of these individuals and our membership's field experience leads us to this proposal.

Statistically, we know that all Older Americans Act programs are serving an even higher age group. From our data, averages for both congregate and in-home participants is now at the mid-70s and beyond. We also know, however, from our experience at the local level that occasionally we see very frail and vulnerable clients that are between the age of 55 and 60. We would like to offer the program to serve clients that we assess as having need for the services. And as we encourage the reauthorization to lower the age of access to our services, we know that there must be a method for increased cost sharing options that would encourage client contribution levels which reflect the client's ability to donate to the program.

While we strongly believe that the initiation of means testing for receipt of services under the Older Americans Act would significantly alter the flavor and effectiveness of the Act, we do, however, acknowledge that some of the participants in our program could contribute more to offset the cost of providing services and we encourage the agency network to creatively look for methods of utilizing sliding scale donations for all programs funded under the Act.

During the years 1981 to 1985, the actual number of meals served increased from 188 million in 1981 to 225 million meals in 1985. Last year, more than 236 million meals were served, a five percent increase over the previous year, despite a 4.3 decrease in funding as a result of Graham-Rudman Hollings Act. We continually produce more units of service every year with either the same or fewer dollars. But the fact is, we are still reaching only a small percentage of the seniors that need our nutrition services, even though the growth of the congregate meals program continues. There is no question that if the problem of hunger and isolation among the elderly is to be seriously addressed, additional funds will be necessary.

Another issue that concerns us is the transfer of funds from one title to another. Currently, approximately 18 percent of all Older Americans Act funds are transferred under the guidelines. All of these funds are transferred out of III C-1 to other programs. We believe that a greater limit needs to be placed on this transfer authority in order to protect the integrity of the Title III program. The transfer of funds should be limited to not more than 15 percent from any one title to another.

Lastly, we would like to see the Title V program maintained as an employment program for low income unemployed persons 55 years of age or older. National contractors too often focus on attempts to transfer workers under the program out of the community work site and into other positions to satisfy quotas. NANASP feels that the young-old, those 55 to 62 years of age, would naturally move into unsubsidized employment because of the need for higher wages.

Often, the demands of family and children are still critical and they are using the Title V program as a means of honing job skills for employment in positions other than their previous careers, while the older worker at the community site feels threatened by movement from one work place to another. The older workers are satisfied with the income provided and are much more interested in the work place environment. They receive a sense of being needed and contributing to someone less fortunate than themselves. This is a key factor in the worker's desire to remain at a nutrition site, senior center, or other aging service provider locations. The nutrition program provides more than meals. It serves as the center for most of the services of the Act around which home delivered meals, transportation, outreach and case management and other supportive services have developed. The congregate meals program serves as an effective cost- saving mechanism from which the elderly can be channeled into appropriate levels of care without the trauma of a community-wide search, so that they remain vital, healthy, and independent for as long as possible.

I would be willing to answer any questions. Thank you.

Mr. Kildee. Thank you very much.

[Prepared statement of Toby Felcher follows:]

PREPARED STATEMENT OF TOBY FELCHER, 2D VICE PRESIDENT, NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS, BALTIMORE, MD

I AM TOBY FELCHER, SPECIAL ASSISTANT TO THE EXECUTIVE DIRECTOR OF THE BALTIMORE CITY COMMISSION ON AGING AND RETIREMENT EDUCATION RESPONSIBLE FOR NUTRITION AND INSTITUTIONAL SERVICES. I AM ALSO SECOND VICE PRESIDENT OF THE NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICES PROGRAMS (NANASP). ON BEHALF OF THE ASSOCIATION, I WANT TO THANK YOU FOR THIS OPPORTUNITY TO PRESENT TESTIMONY ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT (OAA). STUDIES HAVE DEMONSTRATED THE EFFECTIVENESS OF NUTRITION PROGRAMS IN IMPROVING THE QUALITY AND QUANTITY OF THE LIVES OF THE ELDERLY. THE SUPPORT FOR THIS CLEARLY IDENTIFIED PROGRAM IS RESPONSIBLE FOR THE SUCCESS OF THE CONGREGATE MEAL PROGRAM AND THE ACT ITSELF.

IN GENERAL NANASP IS ENCOURAGING CONGRESS TO LOOK AT THIS REAUTHORIZATION AS A FINE TUNING OF THE ACT RATHER THAN A MAJOR OVERHAUL. WE ALSO BELIEVE IN THE NEED TO MAINTAIN THE VARIED LEVELS OF SERVICE THAT ALLOWS US TO BE RESPONSIVE TO THE NEEDS OF OUR OLDER CLIENTS AT VARIOUS POINTS IN THE AGING PROCESS. THE UNIQUE QUALITY OF THE HUMAN SERVICES THAT ARE PROVIDED AS A PART OF THE OLDER AMERICANS ACT IS DIRECTLY LINKED TO THE LEGISLATION'S ORIGINAL DEDICATION TO MAINTAINING INDEPENDENCE, NOT CREATING DEPENDENCE. AND WHILE WE RECOGNIZE THE INCREASING NEED FOR SERVICES FOR THE MORE FRAIL, HOMEBOUND SENIORS, WE FEEL IT IS ESSENTIAL THAT WE FIND A WAY TO MEET THOSE NEEDS WITHOUT DIMINISHING THE STRENGTH OF THE COMMUNITY BASED CONGREGATE PROGRAMS.

NANASP MAINTAINS A FIRM POSITION RESISTANT TO CONSOLIDATION OF THE TITLES IN THE ACT. IT IS OUR BELIEF THAT THE SEPARATE TITLES, AUTHORIZATIONS AND APPROPRIATIONS HELP MAINTAIN THE IDENTITY OF THE PROGRAMS AND STRENGTHEN CONGRESSIONAL SUPPORT.

WE PROPOSE AT THIS TIME THAT THE ELIGIBILITY AGE FOR RECEIPT OF SERVICES UNDER THE OLDER AMERICANS ACT BE REDUCED FROM 60 TO 55 YEARS OF AGE. NANASP

MEMBERS WORKING AT A DIRECT SERVICE LEVEL RECOGNIZE THE NEED FOR GREATER TARGETING OF SERVICES TO MINORITY PARTICIPANTS. THE CURRENT RESTRICTION OF OFFERING SERVICES TO THOSE PERSONS 60 OR OLDER (OR SPOUSES OF ELIGIBLE PARTICIPANTS) OFTEN ELIMINATES MINORITY PERSONS NEEDING ACCESS TO OUR PROGRAMS. THE DOCUMENTED INFORMATION RELATED TO THE PREMATURE AGING AND SHORTENED LIFE EXPECTANCY OF THESE INDIVIDUALS AND OUR MEMBERSHIP'S FIELD EXPERIENCE, LEADS US TO THIS PROPOSAL. LOWERING THE AGE TO 55 WOULD ALSO INCLUDE DISPLACED HOMEMAKERS, WIDOWS AND THOSE INELIGIBLE FOR OTHER BENEFITS DUE TO AGE.

STATISTICALLY WE KNOW THAT ALL OAA PROGRAMS ARE SERVING AN EVEN HIGHER AGE GROUP. FROM OUR DATA, AVERAGE AGES FOR BOTH CONGREGATE AND IN-HOME PARTICIPANTS IS MID-SEVENTIES AND BEYOND. WE ALSO KNOW, HOWEVER, FROM OUR EXPERIENCE AT THE LOCAL LEVEL, THAT OCCASSIONALLY WE SEE VERY FRAIL AND VULNERABLE CLIENTS THAT ARE BETWEEN 55 AND 60 YEARS OF AGE. WE WOULD LIKE TO OFFER THE PROGRAM TO SERVE CLIENTS THAT WE ASSESS AS HAVING A NEED FOR THE SERVICES. AND AS WE ENCOURAGE THE REAUTHORIZATION TO LOWER THE AGE OF ACCESS TO OUR SERVICES, WE KNOW THAT THERE MUST BE A METHOD FOR INCREASING COST SHARING OPTIONS THAT WOULD ENCOURAGE CLIENT CONTRIBUTION LEVELS WHICH REFLECT THE CLIENT'S ABILITY TO DONATE TO THE PROGRAM. WHILE WE STRONGLY BELIEVE THAT THE INITIATION OF MEANS TESTING FOR RECEIPT OF SERVICES UNDER THE OAA WOULD SIGNIFICANTLY ALTER THE FLAVOR AND EFFECTIVENESS OF THE ACT, WE DO HOWEVER, ACKNOWLEDGE THAT SOME OF THE PARTICIPANTS IN OUR PROGRAM COULD CONTRIBUTE MORE TO OFFSET THE COST OF PROVIDING SERVICES AND WE ENCOURAGE THE AGING NETWORK TO CREATIVELY LOOK FOR METHODS OF UTILIZING SLIDING SCALE DONATIONS FOR ALL PROGRAMS FUNDED UNDER THE ACT.

DURING THE YEARS 1981 - 1985 THE ACTUAL NUMBER OF MEALS SERVED INCREASED

20%, FROM 188 MILLION MEALS IN 1981 TO 225 MILLION MEALS IN 1985. LAST YEAR, 1986, MORE THAN 236 MILLION MEALS WERE SERVED, A 5% INCREASE OVER THE PREVIOUS YEAR DESPITE A 4.3% DECREASE IN FUNDING AS A RESULT OF GRAHAM-RUDMAN HOLLINGS ACT. WE CONTINUALLY PRODUCE MORE UNITS OF SERVICE EVERY YEAR WITH EITHER THE SAME OR FEWER DOLLARS. BUT THE FACT IS WE ARE STILL REACHING ONLY A SMALL PERCENTAGE OF THE SENIORS THAT NEED OUR NUTRITION SERVICES, EVEN THOUGH THE GROWTH OF THE CONGREGATE MEALS PROGRAM CONTINUES. THERE IS NO QUESTION THAT IF THE PROBLEM OF HUNGER AND ISOLATION AMONG THE ELDERLY IS TO BE SERIOUSLY ADDRESSED, ADDITONAL FUNDS ARE NECESSARY.

ANOTHER ISSUE THAT CONCERNS US IS THE TRANSFER OF FUNDS FROM ONE TITLE TO ANOTHER. CURRENTLY APPOXIMATELY 18% OF OAA FUNDS ARE TRANSFERED UNDER OAA GUIDELINES. ALL OF THESE FUNDS ARE TRANSFERED OUT OF III C-1 (CONGREGATE) TO OTHER PROGRAMS. WE BELIEVE THAT A GREATER LIMIT NEEDS TO BE PLACED ON THIS TRANSFER AUTHORITY IN ORDER TO PROTECT THE INTEGRITY OF THE TITLE III PROGRAM. THE TRANSFER OF FUNDS SHOULD BE LIMITED TO NOT MORE THAN 15% FROM ANY ONE TITLE TO ANOTHER.

LASTLY, WE WOULD LIKE TO SEE TITLE V MAINTAINED AS AN EMPLOYMENT PROGRAM FOR LOW INCOME UNEMPLOYED PERSONS 55 YEARS OF AGE OR OLDER. NATIONAL CONTRACTORS TOO OFTEN FOCUS ON ATTEMPTS TO TRANSFER WORKERS UNDER THE PROGRAM OUT OF THE COMMUNITY WORK SITE AND INTO OTHER POSITIONS TO SATISFY "QUOTAS". NANASP FEELS THAT THE YOUNG-OLD, THOSE 55 - 62 YEARS OF AGE WOULD NATURALLY MOVE INTO UNSUBSIDIZED EMPLOYMENT BECAUSE OF A NEED FOR HIGHER WAGES. OFTEN THE DEMANDS OF FAMILY AND CHILDREN ARE STILL CRITICAL AND THEY ARE USING THE TITLE V PROGRAM AS A MEANS OF HONING JOB SKILLS FOR EMPLOYMENT IN POSITIONS OTHER THAN THEIR PREVIOUS CAREERS, WHILE THE OLDER WORKER AT THE COMMUNITY SITE FEELS THREATENED BY MOVEMENT FROM ONE WORK PLACE TO ANOTHER. THE OLDER WORKERS ARE COMPLETELY

SATISFIED WITH THE INCOME PROVIDED AND ARE MUCH MORE INTERESTED IN THE WORK PLACE ENVIRONMENT. THEY RECEIVE A SENSE OF BEING NEEDED AND CONTRIBUTING TO SOMEONE LESS FORTUNATE THAN THEMSELVES. THIS IS A KEY FACTOR IN THE WORKERS DESIRE TO REMAIN AT A NUTRITION SITE, SENIOR CENTER OR OTHER AGING SERVICE PROVIDER LOCATIONS.

THE NUTRITION PROGRAM PROVIDES MORE THAN MEALS. IT SERVES AS THE CENTER FOR MOST OF THE SERVICES OF THE ACT, AROUND WHICH HOME DELIVERED MEALS, TRANSPORTATION, OUTREACH AND CASE MANAGEMENT AND OTHER SUPPORTIVE SERVICE HAVE DEVELOPED.

THE CONGREGATE MEALS PROGRAM SERVES AS AN EFFECTIVE COST SAVING MECHANISM FROM WHICH THE ELDERLY CAN BE CHANNELED INTO APPROPRIATE LEVELS OF CARE WITHOUT THE TRAUMA OF A COMMUNITY WIDE SEARCH, SO THAT THEY REMAIN VITAL, HEALTHY AND INDEPENDENT FOR AS LONG AS POSSIBLE.

STATEMENT OF DONNA McDOWELL, DIRECTOR OF WISCONSIN BUREAU OF AGING, CHAIR OF NATIONAL ASSOCIATION OF STATE UNITS ON AGING PUBLIC POLICY COMMISSION, MADISON, WI

Mr. **Kildee**. Donna?

Ms. **McDowell**. Mr. Chairman and distinguished members of the Subcommittee on Human Resources, I am Donna McDowell, Director of the Wisconsin Bureau on Aging and Chair of the Public Policy Committee of the National Association of State Units on Aging. NASUA undoubtedly asked me to testify because Wisconsin poses no threat to Michigan or Iowa in either basketball or football.

I am pleased to present the views of the association on reauthorization and I am only going to briefly highlight some of our issues. I request that our position statement, which you have, be included in the hearing record.

Mr. **Kildee**. It will be included.

Ms. **McDowell**. The Older Americans Act holds out the promise that all citizens of this country may look forward to aging with dignity, self sufficiently as participating members of society. Recent authorizations of this Act have reinforced the view that the Act addresses itself to all older persons, regardless of income, ethnic origin or disabling condition. The Act has also repeatedly strengthened the capacity of state governments and the aging networks they supervise to stimulate service systems and community organizations which are accessible, affordable and responsive to the needs and preferences of older persons.

As state administrators of this act, we view ourselves as having two major responsibilities. First, through our position in state government, we seek policy and program advances which will help other public and private service systems to better respond to the needs of older people. We seek to accomplish these responsibilities by working with the Governor, state legislature, and other agencies in the state government, the aging network and organizations of older people.

Secondly, we develop the policies and state-wide structures for administering the Act at the local level through our partnership with area agencies on aging and program funds authorized under this Act are used to support those services most needed in our communities.

In both our policy changing role and service development role, we are part of larger state human service systems. In Washington, DC, too often the Older Americans Act is seen in a vacuum as a free standing program totally separate from services funded by the Social Services Block Grant, Medicaid home and community based services, Medicare, state supplements to SSI and so on.

By contrast, in our states, the Older Americans Act is one component of a human service system greatly influenced by these other larger programs which we in turn seek to influence on behalf of older persons. In order to best meet the needs of older people, we must make sure that the services funded under the Older Americans Act are provided in a way that complements these programs.

This reality provides the framework for the association's reauthorization position.

We affirm our opposition to any federal requirements to spend a specific amount of Title III-B funds on any single service category. If we are to be responsive to the diverse needs of older people across this country, then we must be able to reflect differences in services and funding availability from state to state and from community to community.

We remind you that the governance of these decisions at the local level is generally in the hands of older people.

The vast differences among state human service systems also shape our viewpoint as to how to best target services to meet those in greatest need. Over the past decade, we have become increasingly frustrated by Older Americans Act policies which we believe to be unnecessarily restrictive and contradictory. While we are to target services to the most disadvantaged, we are directed to achieve this objective without considering the incomes of potential service recipients. Our statements calls for Congress to clarify the objectives of the law regarding targeting and to give states the policy tools which we need to create a more rational role for the Older Americans Act in the context of larger human service systems.

First, we do ask you to reaffirm that the Act is intended to develop effective programs and opportunities for all older Americans regardless of income, ethnic origin or disabling condition. This mission should continue to guide the activities of the organizations which comprise the aging network so that older persons continue to be viewed not as clients or dependents, as in traditional social service organizations, but as participants, volunteers, planners, leaders and advisors in the development of responsive public and private programs in which any older person can participate with dignity and without social sigma.

Secondly, however, we believe that states should have the authority to selectively apply cost-sharing principles to service programs funded under the Act on either a voluntary or a mandatory basis. Currently, only voluntary contribution systems are legal, but pressure is mounting in under funded programs to establish fees, not always related to ability to pay. We would prefer to have the option of establishing cost-sharing plans on an ability to pay basis using Title III funds to supplement or wholly subsidize the cost based on a participant's income.

Absent this provision, older Americans in one community may be making a co-payment for a service funded under Medicaid or Social Service Block Grant while elsewhere in the same state, the service may be free because it is funded through Title III. It is difficult to establish equity in state human service systems when multiple funding sources are employed to create those service delivery systems.

I do not personally believe that cost-sharing is an onerous concept to older persons. Wisconsin operates an entirely state funded Community Options Program, which at $25 million annually is five times larger than our Title III-B allocation, is designed to assist disabled persons of all ages and incomes to remain in the community. We have a cost-sharing plan that considers income and extraordinary personal expenses to determine how much an individual pays for services they choose, ranging from zero to 100 percent of the cost.

Fully one fourth of all participants, mostly elderly, pay the full cost of community care just as they would pay the full cost of nursing home care. Older people are great advocates for the Community Options Program in Wisconsin in part because it is not a welfare program or a program for the poor—it is open to people who are middle and upper income. They know that middle class elderly need the same help as the poor to organize the care that will keep them at home.

Thirdly, our policy statement cautions that mandatory cost-sharing options should not be permitted for certain advocacy and access services such as information and referral, outreach, the ombudsmen, protective services, and case management. Advocacy and access services of the aging network are often the only means older persons have of learning about programs and benefits and getting the necessary advise and assistance to negotiate the maze of public and private benefit programs and freely make choices about what programs to participate in.

These three elements would contribute to the ability of states and area agencies to target service funds to persons in greatest need while maintaining our role to establish systems and organizations which are responsive to all older Americans. We do not seek to limit participation in the Older Americans Act to the poor. We seek the flexibility to identify those Title III services analogous to the ones serving the elderly under other funding sources where some co-payment based on an income scale would be viewed as resonable, equitable and not demeaning to older participants.

Finally, as a reflection of national concern for quality of care provided both in a client's own home and in nursing homes, we propose the establishment of a new sub-title of Title III with two separate components.

The first part would include legislative authority for the state long term care ombudsman programs and provide for a separate appropriation. Provisions which we feel should be added to the current legislative language include granting obmudsmen limited immunity from civil suits, ensuring ombudsmen access to patients in hospitals who have been transferred from nursing homes, and protecting the ombudsman program from the impact of OMB Circular A-122.

We propose that a second part of this new sub-title provide an authorization of funds for state units and area agencies to develop state-specific quality assurance initiatives on behalf of elderly persons receiving in-home services in which public funds are involved. We seek sufficient flexibility in this authorization to enable us to participate in quality assurance efforts in any publicly funded community based long term care program as determined by our Governors.

In closing, I would like to express our appreciation and support for your initiative to add a new title expanding in-home services to older Americans, clearly the most critical area we are dealing with.

Mr. Chairman, in consideration of your limited time, I have discussed only a few of our policy positions and I thank you for the opportunity to share our views.

Mr. KILDEE. Thank you very much.

[The prepared statement of Donna McDowell follows:]

PREPARED STATEMENT OF DONNA MCDOWELL, DIRECTOR, WISCONSIN BUREAU OF AGING AND CHAIR, NASUA PUBLIC POLICY COMMITTEE

Mr. Chairman and distinguished members of the Subcommittee on Human Resources. I am Donna McDowell, Director of the Wisconsin Bureau on Aging and Chair of the Public Policy Committee of the National Association of State Units on Aging. I am pleased to present the view points of the Association on Reauthorization of the Older Americans Act. In my oral testimony I will only briefly highlight several issues and I request that our full position statement on reauthorization be included in the hearing record.

The Older Americans Act holds out the promise that all citizens of this country may look forward to aging with dignity, self-sufficiently as fully participating members of society. Recent reauthorizations of this Act have reinforced the view that the act is addressing itself to all older persons, regardless of income, ethnic origins or disabling conditions. The Act has also repeatedly strengthened the capacity of state governments and the aging networks they supervise to stimulate services systems and community organizations which are accessible, affordable and responsive to the needs and preferences of older people.

As state administrators of this Act, we view ourselves as having two major responsibilities. First, through our position in state government, we seek policy and program advances which will help other public and private service systems to better respond to the needs of older people. We seek to accomplish these responsibilities by working with the Governor, state legislature, other agencies in state government, the aging network, and organizations of older people.

Secondly, we develop the policies and statewide structures for administering the Act at the local level. Through our partnership with area agencies on aging, the program funds authorized under this Act are used to support those services most needed in our communities.

In both our policy change role and services development role we are part of a larger state human services system. In Washington D.C., too often the Older Americans Act is seen in a vacuum - as a free-standing program totally separate from services funded by the Social Services Block Grant, Alcohol, Drug Abuse and Mental Health Block Grant, Medicaid Home and Community Based Services, Medicare, state supplements to SSI and other programs established and supported through state revenues or private financing. By contrast, in our states the Older Americans Act is one component of a human services systems, greatly influenced by these other larger programs which we in turn seek to influence on behalf of older persons. In order to best meet the needs of older people, we must make sure that the services funded under the Older Americans Act are provided in a way that compliments these other programs. This reality provides the framework for the Association's reauthorization position.

We reaffirm our opposition to any federal requirements to spend a specific amount of Title III-B funds on any single service category. If we are to be responsive to the diverse needs of older people across this country, then we must be able to reflect differences in service and funding availability from state to state and from community to community.

The vast differences among state human services systems also shape our viewpoint on how to best target services to those older persons most in need. Over the past decade we have become increasingly frustrated by Older Americans Act policies which we believe to be unnecessarily restrictive and contradictory. While we are to target services to the most disadvantaged, we are directed to achieve this objective without considering the incomes of potential service recipients. Our statement calls for Congress to clarify the objectives of the law regarding targeting, and to give states the policy tools which we need to create a more rational role for the Older Americans Act in the context of larger human services systems.

First, we ask you to reaffirm that the Act is intended to develop effective programs and opportunities for all Older Americans, regardless of income, ethnic origin or disability condition. This mission should continue to guide the activities of the organizations which comprise the aging network, so that older persons continue to be viewed not as clients or dependents but as participants, volunteers, planners, leaders, and advisors in the development of responsive public and private programs in which any older person can participate with dignity and without social stigma.

Secondly, however, we believe that states should have the authority to selectively apply cost-sharing principles to service programs funded under the Act, on a either a voluntary or mandatory basis. Currently, only voluntary contribution systems are legal, but pressure is mounting in under funded programs to establish fees - not always related to ability to pay. We would prefer to have the option of establishing cost-sharing plans on an ability-to-pay basis using Title III funds to supplement or wholly subsidize cost, based on participants' income. Absent this provision, older persons in one community may be making a co-payment for a service funded under Medicaid or Social Service Block Grant, while elsewhere in the same state the service maybe free because it is funded through Title III. It is difficult to establish equity in a state human service system when multiple funding sources are employed to create service delivery systems.

I do not personally believe that cost-sharing is an onerous concept to older persons. Wisconsin operates an entirely state-funded Community Options Program (which at $21 million annually is five times larger than our III-B allocation) which is designed to assist disabled persons of all ages and incomes to remain in the community. We have a cost-sharing plan that considers income and extraordinary personal expenses to determine how much an individual pays for services, ranging from 0 to 100 percent of costs. Fully one fourth of all participants (mostly elderly) pay the full cost of community care (just as they would pay the full cost of nursing home care). Older people are great advocates of the Community Options Programs, in part because it is open to people who are middle and upper income. They know that middle class elderly need the same help as the poor to organize the care that will keep them at home.

Thirdly, our policy statement cautions that mandatory cost-sharing options should not be permitted for certain advocacy and access services such as information and referral, outreach, ombudsman, protective services, and case management. Advocacy and access services of the aging network are often the only means older persons have of learning about programs and benefits, and getting the necessary advice and assistance to negotiate the maze of public and private benefit programs.

These three elements would contribute to the ability of states and area agencies to target service funds to persons in greatest need, while maintaining our role to establish systems and organizations which are responsive to all older Americans.

Finally, as a reflection of NASUA's concern for quality care provided both in a client's own home and in nursing homes, we propose the establishment of a new sub-title of Title III with two separate components. The first part would include legislative authority for the state long term care ombudsman programs and provide for a separate appropriation. Provision which we feel should be added to the current legislative language include:

- o Granting ombudsmen limited immunity from civil suits for good faith performance of their duties;

- o Ensuring ombudsmen access to patients in hospitals who have been transferred to hospitals from nursing homes; and

- o Protecting the ombudsman program from the impact of OMB Circular A-122.

We propose that a second part of this new sub-title provide an authorization of funds for state units and area agencies to develop state - specific quality assurance initiatives on behalf of elderly persons receiving in-home services in which public funds are involved. We seek sufficient flexibility in this authorization to enable us to participate in quality assurance efforts in any publicly-funded community based long term care program, as determined by our Governors.

Mr. Chairman, in consideration of the Committee's limited time, I have discussed only a few of our policy positions. Thank you for the opportunity to share our views. I would be happy to respond to any questions of the Committee.

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THE 1987 REAUTHORIZATION OF OLDER AMERICANS ACT

A Joint Statement
of the
National Association of Area Agencies on Aging
and the
National Association of State Units on Aging
Washington, D.C.

Positions Adopted by the NAAAA and NASUA Membership
August, 1986

600 Maryland Avenue, S.W., Suite 208, Washington, D.C. 20024

PREAMBLE

The Older Americans Act as originally written and amended is structurally sound. It has created an advocacy and service network that addresses the needs of older persons through a community system of monitored, quality care. At this time the Act does not need major structural changes. The following are "fine-tuning" recommendations for change. Items underlined are new additions recommended for insertion into existing statute, and items within parentheses are existing language of statute recommended for deletion.

1. REAUTHORIZATION PERIOD

It is recommended that the Older Americans Act be reauthorized for a period of three years, or through September 30, 1990. Concerning the time period for State and Area plans - it is recommended that the current language in Section 307(a) be retained: ...each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Commissioner a State plan for a two-, three-, or four-year period.

2, TITLE I

The following changes in Title I are to emphasize that the Older Americans Act advocates in behalf of: all aging persons, a broader perspective than just those over 60 years of age; and older persons as a group, not just for individuals. We also wish to: emphasize that older persons contribute to society as well as earn rights from it; address the current intergenerational issues by encouraging participation with other age groups; call attention to the need for protection against abuse; and recognize the important role of care givers of the elderly.

There are currently ten subsections in Section 101 of Title I. The proposed changes add new language to subsection 2,3,7 and 10. In addition, a new subsection 11 is added.

Section 101(2) The best possible physical and mental health which science can make available and at costs which older citizens can afford. (without regard to economic status.)

Section 101(3) To be able to obtain and maintain suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.

Section 101(7) Participate and contribute in (Pursuit of) meaningful activity within the widest range of civic, cultural, education and training and recreational opportunities with their peers and citizens of other generations

Section 101(10) Freedom, independence and the free exercise of individual initiative in planning and managing their own lives; protection against abuse, neglect and exploitation; and full participation...

(new) Section 101(11) Support to family members and others providing voluntary care to those older citizens needing long term care services.

3. TITLE II - PLACEMENT OF AOA

An Assistant Secretary for Aging should be established within the Department of Health and Human Services with responsibility for representing the interests of all older Americans within DHHS and with other federal departments and agencies, and for administering the Older Americans Act program.

If the Act is not changed to provide for an Assistant Secretary for Aging the following is proposed for the Office of the Commissioner on Aging.

Section 201(a)...there shall be a direct reporting relationship between the Commissioner and the (Office of the) Secretary. In the performance of the functions of the Administration, the Commissioner shall be directly responsible to the (Office of the) Secretary.

Section 202(a)(8) gather statistics in the field of aging, through the National Data Base on Aging sponsored by NAAAA and NASUA, which other Federal agencies are not collecting...

Section 207(a) not later than one hundred and twenty days after the close of each fiscal year, the Commissioner shall prepare and submit to the President and to the Congress a full and complete report on the activities carried out under this Act. Such annual reports shall include statistical data reflecting services and activities provided individuals during the preceding fiscal year. In addition, the Commissioner shall prepare and submit a plan of action for the new fiscal year, in consultation with State Units on Aging and Area Agencies on Aging, outlining specific goals and objectives to be met to implement the purposes of this Act.

4. AUTHORIZATION OF APPROPRIATIONS

The figures proposed here represent a 5% increase in authorized funding levels for Title III, for each of the three fiscal years.

Section 303(a) There are authorized to be appropriated $379,575,000 for fiscal year 1988, $398,554,000 for fiscal year 1989, and $418,482,000 for fiscal year 1990 for the purpose of making grants under part B...

b(1) these are authorized to be appropriated $414,750,000 for fiscal year 1988, 435,488,000 for fiscal year 1989, and $457,262,000 for fiscal year 1990 for the purpose of making grants under subpart 1 of part C...

(2) these are authorized to be appropriated $79,380,000 for fiscal year 1988, $83,349,000 for fiscal year 1989, and $87,516,000 for fiscal year 1990 for the purpose of making grants under subpart 2 of part C...

5. SINGLE ORGANIZATIONAL UNIT

This proposed language supports a single organizational unit functioning as the Area Agency on Aging. This does not prohibit the placement of an Area Agency on Aging within an umbrella agency, such as a council of governments, a regional planning district, city or county governments. It does however strengthen the Area Agency by assuring that it is a separate, identifiable unit within such an umbrella agency, assuring access to services and advocacy for older persons needing assistance.

Section 305(c)(2) any office or agency of a unit of general purpose local government, which is a single organizational unit designated for the purpose of serving as an area agency by the chief elected official of such unit.

Section 305(c)(3) any office or agency which is a single organizational unit designated by the appropriate chief elected officials of any combination of units of general purpose local government to act on behalf of such combination for such purpose.

Section 305(c)(4) any public or nonprofit private agency in a planning and service area, or single organizational unit within it, which is under the supervision or direction for this purpose of the designated State agency and which can engage in the planning or provision of a broad range of supportive services, or nutrition services within such planning and service area.

6. DESIGNATION

The intent of both organizations is to require State Agencies on Aging to hold a public hearing in the event of a change in the designation of planning and service boundaries. Below is language that attempts to strengthen the assurance that a newly designated area agency will be fully qualified to fulfill its mandates.

Section 305(c) an area agency on aging designated under subsection (a) shall be—[subsections 1 through 5 as amended above].....
and shall provide assurance, determined adequate by the State agency through an on-site assessment, that the area agency will have the ability to develop an area plan....

7. COST SHARING

The climate appears to be right for greater attention to cost sharing by participants for the services being provided to them. The intent of the changes here are to require that voluntary contributions be sought for III-B and III-C, and to allow States and Area Agencies to develop cost sharing for selected services.

To accomplish this a new subsection (L) is added to Section 306(a)(6). The language in this new paragraph is adapted from the wording in Section 307(a)(13)(C) which permits the solicitation of voluntary contributions for the nutrition program. A new subsection (F) is added to 305(a)(2) to provide for cost sharing.

In addition - Section 307(a)(17)(C) is amended to say that projects will solicit voluntary contributions.

Section 305(a)(2) the State agency designated under clause (1) shall—

(New) Section 305(a)(2)(F) be permitted to establish procedures for either voluntary or mandatory cost sharing for selected services on an ability to pay basis. Such mandatory cost sharing shall not be applied to limit such services as information and referral, outreach, and advocacy services, including ombudsman and protective services, which must be available to all persons 60 or over.

Section 306(a)(6) provide that the Area Agency on Aging will

(New) Section 306(a)(6)(L) solicit voluntary contributions for services furnished in accordance with guidelines established by the commissioner.

taking into consideration the income ranges of individuals in local communities and requirements imposed by other sources of funds of the recipient of a grant or contract, and such voluntary contributions will be used to maintain or increase services of the program...[consistent with 307(a)(13)(c)]

Section 307(a)(13)(C)(i)...each project will (permit recipients of grants or contracts to) solicit voluntary contributions... State agencies shall assure that cost-sharing plans do not inhibit giving priority to persons in greatest social and economic need.

8. TARGETING

The Associations support the existing language within 305(a)(2)(E) providing the assurance that "older individuals with the greatest economic or social needs, with particular attention to low income minority individuals", will be given preference for services. We also wish to target limited resources to the frail elderly through case management services and the utilization of functional assessments through the following addition:

Section 306(a)(6)(I) conduct efforts to facilitate the coordination of community-based, long term care services designed to retain individuals in their homes, thereby deferring unnecessary or inappropriate, costly institutionalization, and designed to emphasize the development of client centered case management systems through the utilization of functional assessments to determine need for services.

9. ADVOCACY

The following changes represent "fine tuning" on the matter of State and Area Agency advocacy efforts. Language is taken from OAA regulations to accomplish this. The changes accomplish: an emphasis on the fact that the

Act is for all older persons; State and Area Agencies have the right to comment on appropriate State and Federal matters affecting their constituents, but not necessarily required to comment on all such matters (as they may not have the capacity to do so). Periodic public hearings by State and Area Agencies are called for.

Section 305(a)(1)(D) serve as an effective and visible advocate representing the interests of older Americans (for the elderly) by reviewing and commenting upon (all) State and Federal plans, budgets, and policies which affect the elderly...

Section 306(a)(6)(A) conduct periodic evaluations (of) and public hearings on activities carried out under the area plan.

Section 306(a)(6)(D) serve as the advocate and focal point for the elderly within the community by monitoring, evaluating, and commenting upon (all) policies, programs, hearings, levies, and (community) actions which will affect the elderly regardless of any prohibitions of OMB A-122.

Section 307(a)(8) provide that the State agency will conduct periodic evaluations (of) and public hearings on activities and projects carried out under the State plan.

10. NUTRITION

The purpose of the following change is to allow the use of nutrition funds for services that may be needed but not clearly allowable for nutrition program participants.

Section 331(3)...which may include nutrition education services and other appropriate (nutrition) services (for older individuals) to meet the special needs of target groups [e.g. frail, minority, limited English-speaking, or disabled persons] among the participants, as established by State Title III policy.

11. COMMODITIES

The authorization of appropriations for the USDA Commodity Distribution program is increased by 10% over the next three years.

Section 311(4)...level of assistance of not less than 59.60 cents per meal during fiscal year 1988 and 1989, and 62.60 cents for fiscal year 1990.

Section 311(e)(1)(A)...there are authorized to be appropriated $151.2 million for fiscal year 1988, and 1989, and $158.76 million for fiscal year 1990 to carry out...

12. QUALITY ASSURANCE

The Long Term Care Ombudsman program should be a separate subsection of Title III with a separate authorization of appropriations. References to the ombudsman program found in Sections 304, 307 and 321 should be incorporated into the new subsection.

As a result of the growing elderly population living longer and healthier, and as a result of changes in the Medicare system returning patients to their homes for care, more older people are receiving in-home care services than ever. At the same time this trend is occurring, the federal government has reduced its regulatory responsibilities for in-home and institutional care and the public and Congress are calling for accountability, assuring that older persons are indeed receiving the quality services they need.

The aging network administering the OAA, currently is responsible for the monitoring of in-home services which it funds, as well as monitoring the care of elderly persons living in institutions. It is therefore reasonable to extend these oversight responsibilities on behalf of all elderly receiving publicly funded home care.

A new subsection, incorporating the strengthened ombudsman program, and the responsibility for in-home services monitoring by the State and Area Agencies is proposed as follows:

Title III

PART D - STATE AND AREA AGENCY ON AGING QUALITY ASSURANCE PROGRAM.

Subpart 1 - Long Term Care Ombudsman Program.

The following provisions should be included in the statutory language (307(a)(12) regarding assurances that the state agency will establish and operate...a long term care ombudsman program:

- o Ombudsmen should be granted limited immunity from civil suits for good faith performance of their duties.
- o Ensure ombudsmen access to patients in hospitals who have been transferred to hospitals from nursing homes.
- o Provide language which protects the ombudsman program from the impact of OMB Circular A-122.

  Also - in order to emphasize the role of the State Unit on Aging in the ombudsmen program - the following is proposed:
- o Section 307(a)(12) - provide assurances that the State Agency [State Unit on Aging] will...

The inclusion of the word agency puts the responsibility for the ombudsman program with the State agency (state unit on aging) designated to administer the Older Americans Act.

Subpart 2 - ~~Home and~~ Community Care Quality Assurance Program.

This subsection should provide statutory language for the State and Area Agencies to develop a quality assurance program for elderly persons receiving in-home services in which public funds are involved.

A separate authorization of appropriations should be provided for subsections 1 and 2 of new Part D.

13. LIABILITY

To address the growing concerns about liability issues the association will pursue statutory language similiar to that in legislation of the Health Systems Agencies. It is proposed:

> In general - Except as provided in subparagraph (B) - (i) an Area Agency on Aging shall not, by reason of the performance of any duty, function, or activity, required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision thereof) if the member of the governing body, an advisory council of the agency or employee of the agency who acted on behalf of the agency in the performance of such duty, function, or activity acted within the scope of his duty, function, or activity as such a member or employee, exercised due care, and acted without malice toward any person affected by it; and (ii) no individual member of the governing body or advisory council of an Area Agency on Aging or employee of an Area Agency on Aging shall, by reason of his performance on behalf of the agency of any duty, function, or activity required of, or authorized to be undertaken by, the agency, be liable for the payment of damages under any law of the United States or any State (or political subdivision of a State) if he believed he was acting within the scope of this duty, function, or activity as such a member or employee, and with respect to such performance, acted without gross negligence or malice toward any person affected by it.

(B) Exception - Subparagraph (A) does not apply with respect to civil actions for bodily injury to individuals or physical damages to property brought against an Area Agency on Aging or any member of the governing body advisory council of or employee of such an agency.

14. TITLE IV

The language proposed here clearly identifies the role of the two associations in the establishment and operation of the National Data Base on Aging and sets forth certain priority areas for Title IV funds.

Section 420(2) establish an information base of data and practical experience with particular emphasis on the National Data Base on Aging established by the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

(New) (6) Provide technical assistance to State Units on Aging and Area Agencies on Aging in carrying out their responsibilities.

Section 422 (b)

(New) (9) Address the causes and remedies associated with neglect abuse and exploitation of the elderly.

(New) (10) Demonstrate quality assurance practices for long term care services.

(New) (11) Promote affordable long term care services.

15. TITLE V

The language proposed here is to require that the National Contractors cooperate with the State Units on Aging in developing a statewide plan for the allocation of job slots in each State. There is also a provision calling for cooperation between the National Contractors and the JTPA program at the State and local level.

In the absence of statutory language requiring a jointly produced State plan - it is recommended that the law should at least require that procedures be established and implemented that will assure coordination of all Title V slots in each State.

Section 502(d)(1)...whenever a national organization or other program sponsor conducts a project within a State such organization or program sponsor shall, participate with the State Unit on Aging in joint development of a statewide operational plan including equitable distribution of slots within the state for the Community Services Employment for Older Americans Program, for the approval of the Governor of the State. National contracting organizations shall cooperate at the state and local levels with the state Job Training Partnership Act program. (submit to the State agency on aging a description of such project to be conducted in the State, including, the location of the project, 30 days prior to undertaking the project, for review and comment according to guidelines the Secretary shall issue to assure efficient and effective coordination of programs under this title.)

16. TITLE VI

The position on Grants for Indian Tribes in the reauthorization is to continue to support direct funding to Indian tribes, and to call for an appropriation which is at a level adequate to serve the eligible constituency.

(New) Section 604(a) (10) Title VIII recipients will not be precluded from receiving Title III services.

17. INTERGENERATIONAL ACTIVITIES

In recognition of the growing dialogue on the subject of intergenerational matters it is proposed that there be language in the Act that acknowledges the contributions that the elderly are capable of making to children and youth - and to encourage intergenerational activities. The following change is proposed

Section 306(a)(6)(E)...where possible, enter into arrangements with organizations providing services to benefit children so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, especially those in poverty in alternate care or under protective services; and to encourage where possible other intergenerational activities.

STATEMENT OF RUSSELL PROFFITT, DIRECTOR OF HERITAGE AREA AGENCY ON AGING, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, CEDAR RAPIDS, IA

Mr. KILDEE. Russ?

Mr. PROFFITT. Mr. Chairman and members of the Subcommittee on Aging, I am Russ Proffitt, Director of the Heritage Area Agency on Aging in Cedar Rapids, Iowa. I am a member of the Board of Directors of the National Association of Area Agencies on Aging which represents the boards, advisory councils, service providers and staff of over 670 area agencies on aging nationwide.

Our association does not see the need for a major overhaul of the Act, but we do believe that some fine tuning will be helpful. The NAAA position on detailed revisions has been submitted to your committee for your consideration.

Significantly, the Older Americans Act in Medicaid and Medicare were enacted in the same year, 1965. Although it was dwarfed by the two large health funds, the evolution of the Older Americans Act has been critically linked to the development of the other two larger systems. In the early years, most social services funded by the Older Americans Act were social and recreational, designed to bring older persons together to combat loneliness. It was believed, then, that truly serious problems could be met primarily through income or health programs.

By the early 1970s, concern began to grow about the health care emphasis on institutionalization, especially in nursing homes. Studies revealed that many nursing home residents did not have to be there. This triggered Amendments in the 1973 reauthorization of the Act that established the area agencies on aging who would be the planners and coordinators of all community based services.

The Title III mandate was for area agencies to "establish comprehensive coordinated systems of services for the aging which would enable older persons to live in their own homes or other places of residence as long as possible."

With the prodding of the Administration on Aging under the leadership of Commissioner Bennedict, the agenda of long term care was changed from institutional care to community based care. Channeling grants were awarded to several areas. Area agencies began to work toward alternatives to institutionalization, but not without considerable political resistance.

Title III itself, while strong in its intent, was weak in the authority it vested in the area agencies to develop and manage resources to serve those in greatest need. Instead, the Act's unlimited list of fundable services led many service providers to feel that the Act was an entitlement program for established providers. Meanwhile, the largest programs in the act, nutrition and employment, remained categorical, lending credence to the view that the cause of the frail, vulnerable elderly was not as pressing an issue.

Over the past decade, area agencies across the nation, true to the intent of the Act, have increasingly focused on those struggling to stay in their own homes. We have learned that these vulnerable people are older, sicker, poorer, and more isolated than other elders. Most often, they are stricken with a disabling, chronic disease at a time when pensions have lost their purchasing power.

Many are widows without work histories who are not eligible for their husbands' pensions. More than half of the elderly served by area agencies are 75 and older. Most have troubles other than their disabilities, including malnutrition, depression, intense loneliness, as well as homes in disrepair, need for homemaking help, and chore services. Because they are invisible, their numbers are grossly underestimated.

We have learned, and research has substantiated, that while nursing homes are considered health care institutions, health care is not the primary reason for people to go into nursing homes. The primary reason is difficulty with ordinary activities of daily living and the lack of affordable supportive services in the home to make the activities of daily living possible.

While an elderly person may need continuing health care after being discharged from a hospital, the need for health care usually diminishes in a few months. But if support services are not in place, an elderly person may likely be a candidate for a nursing home. Significantly, when health care eligibility runs out, the burden of care falls most frequently on Title III–B of the Older Americans Act, the most neglected portion of the act.

In several states, state units and area agencies on aging have developed solid systems serving the vulnerable elderly, drawing in Older Americans Act, Social Services Block Grant, Medicaid, Medicare and/or other state and county revenues and integrating them through case management activities. We are pleased these models received recognition for success through the Congressional mandate of the 1984 reauthorization instructing area agencies to facilitate the coordination of community based long term care services, to emphasize the development of client centered case management systems as a component of such services.

In a period where we see major growth in our old, old population, major changes in the Medicare program are placing new stresses on the community care systems. Rapid growth is occurring in the entire health care market with new providers grasping for a piece of the action. It is no wonder older persons and their care givers find our entire health and community care systems a confusing maze to work through. The growth of community-wide case management systems has been very important to the elderly in these confusing times.

Since the implementation of DRGs in the 1980s, area agencies on aging have experienced tremendous growth in the utilization of their services. Agencies report that they are spending a disproportionate percentage of their funds on services for the frail homebound person. The increases reflect new demands on community based and in-home services provided by the area agencies under Title III–B.

A major question that needs to be asked during this reauthorization is, do we intend for the Older Americans Act to supplement Medicare through home care and support services and if so, how, without additional funds to meet the demands? We recommend that a mere one percent of the savings resulting from the Medicare cost containment measures of DRGs be transferred for home and supportive services under the Older Americans Act.

I have purposely outlined some critical points in the history of area agencies that demonstrate our ability to be a responsive and strong network. We look to your committee to continue to support the successes of our networks, but also to assist us in strengthening it through this reauthorization. We are seeking continued flexibility to determine the needs of our local communities, taking into consideration not only the growing number of elderly persons who have unmet needs, but also the supply and demand of our services and the community's resources which enable us to support those critical services.

We continue to oppose the State Block Grant approach. It does not provide for decision making at the community level and it diffuses responsibility and weakens advocacy.

We want to maintain a strong network at the federal, state and local levels. The Administration on Aging needs to provide the leadership for this network. The Commissioner needs to have the authority to collaborate with other federal agencies which assist us in building the bridges which we must cross at the local level. For example, stronger relationships are needed with the Departments of Transportation and Housing to better enable us to address the critical needs at the local level.

We continue to believe that AOA's strength can be better achieved only if the Commissioner is at an Assistant Secretary level or at the least reports directly to the Secretary of Health and Human Services rather than be buried within the Office of Human Development Services.

Strengthening the network at the local level can be enhanced by encouraging the further development of our community based long term care systems. NAAA is seeking to strengthen the role of the financially disinterested area agency on aging in managing and brokering services through case management. We continue to emphasize the importance of the advocacy role of the area agency representing the interests of older Americans before local, state and federal decision makers.

The area agencies have taken seriously the need to wisely use limited resources. We have tightened service delivery by targeting where possible. We utilize thousands of volunteers in creative ways. We have moved to manage our programs more efficiently through computerization and we have implemented support groups to expand the use of family and neighbor care givers.

We are now operating with minimal resources compared to demand. The time may be now to consider increased cost-sharing by participants for services when possible. We are seeking a mechanism to establish voluntary cost sharing without transitioning the program to a means tested program.

Much attention has come to the ombudsman program as a result of changes in the Medicare and Medicaid programs. We support efforts to strengthen the authority of this program under the Older Americans Act and to enhance its role within the state and area agency network. We cannot further enhance and expand this program, however, at the expense of other Title III-B services. We are, therefore, seeking new appropriations under a separate title for the ombudsman program.

Enacted measures to permit Medicare and Medicaid to subsidize health care in the home have created another problem—major growth in the home care industry. When a single local home health service provider operated a modestly funded project, there was little potential for abuse. But today, competition is keen and providers turn on the hard sell for clients. Some providers have much professional integrity, but others are exploitive. We have seen expansive health care provided where much less expensive social supportive services or even trained family members could adequately provide the needed services. This over-utilization is the product of a poorly monitored and managed system. Frequently and duration of service—frequency and duration of service for captive clients can be set by the providers who in turn profit from the service delivery.

Home care services is funded with less utilization review and monitoring than nursing homes, and the potential for abuse exists. Considering the role of the area agency on aging to advocate on behalf of clients in the case management system—in the case management and ombudsman programs as well as their mandate to monitor services within their planning and service area, we support the development of a role for the aging network in this critical advocacy process.

To meet this increased responsibility, a separate sub-section of the new Older Americans Act Title III–D, referenced earlier, may be important to consider.

The aging network is a proven and existing network that covers the entire country. We are the logical entity to assume some of these newly proposed responsibilities, but not at the expense of the original intent of the Older Americans Act—that is, to assist older persons to remain in their communities and homes. We, therefore, are seeking your support to assure the integrity of the current Title III–B programs and to assist us in finding new or transferred funds, whether they are from Medicare, Medicaid, or public health, to successfully fulfill these roles.

We should not listen to discussions about reductions in services for needy older persons. Rather, we should be planning for responsible ways to supply even more needed services to this dramatically expanding population. We cannot allow changes in public policy to erode a very limited support system for needy older persons. We need the continued support of your committee to meet these critical challenges under the Older Americans Act.

Thank you.

[The prepared statement of Russell Proffitt follows:]

PREPARED STATEMENT OF RUSSELL PROFFITT, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING, CEDAR RAPIDS, IA

REPRESENTATIVE KILDEE, REPRESENTATIVE TAUKE, AND MEMBERS OF THE SUBCOMMITTEE ON AGING, MY NAME IS RUSS PROFFITT, DIRECTOR OF THE HERITAGE AREA AGENCY ON AGING IN CEDAR RAPDIS, IOWA. I AM A MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING WHICH REPRESENTS THE BOARDS, THE ADVISORY COUNCILS, SERVICE PROVIDERS AND STAFF OF OVER 670 AREA AGENCIES ON AGING NATIONWIDE. THANK YOU FOR GIVING OUR ASSOCIATION THE OPPORTUNITY TO COMMENT ON THE PENDING REAUTHORIZATION OF THE OLDER AMERICANS ACT.

SIGNIFICANTLY, THE ORIGINAL OLDER AMERICANS ACT AND MEDICAID /MEDICARE WERE ENACTED THE SAME YEAR.. 1965. ALTHOUGH IT WAS DWARFED BY THE TWO LARGE HEALTH FUNDS, THE EVOLUTION OF THE OLDER AMERICANS ACT HAS BEEN CRITICALLY LINKED TO THE DEVELOPMENT OF THE OTHER TWO LARGER SYSTEMS. IN THE EARLY YEARS MOST SOCIAL SERVICES FUNDED BY THE OLDER AMERICANS ACT WERE SOCIAL AND RECREATIONAL DESIGNED TO BRING OLDER PERSONS TOGETHER TO COMBAT LONELINESS. IT WAS BELIEVED THAT TRULY SERIOUS PROBLEMS COULD BE MET PRIMARILY THROUGH INCOME OR HEALTH PROGRAMS.

BY THE EARLY 1970'S, CONCERN BEGAN TO GROW ABOUT THE HEALTH CARE EMPHASIS ON INSTITUTIONALIZATION, ESPECIALLY IN NURSING HOMES. STUDIES REVEALED THAT MANY NURSING HOME RESIDENTS DID NOT HAVE TO BE THERE. THIS TRIGGERED AMENDMENTS IN THE 1973 REAUTHORIZATION OF THE OLDER AMERICANS ACT THAT ESTABLISHED THE AREA AGENCIES ON AGING, WHO WOULD BE THE PLANNERS AND COORDINATORS OF ALL COMMUNITY BASED SERVICES. THE TITLE III MANDATE WAS FOR

AREA AGENCIES TO "ESTABLISH COMPREHENSIVE, COORDINATED SYSTEMS OF SERVICES FOR THE AGING" WHICH WOULD "ENABLE OLDER PERSONS TO LIVE IN THEIR HOMES OR OTHER PLACES OF RESIDENCE AS LONG AS POSSIBLE".

AREA AGENCIES BEGAN TO WORK TOWARD ALTERNATIVES TO INSTITUTIONALIZATION BUT NOT WITHOUT CONSIDERABLE POLITICAL RESISTANCE. TITLE III ITSELF, WHILE STRONG IN ITS INTENT, WAS WEAK IN THE AUTHORITY IT VESTED IN THE AREA AGENCIES TO DEVELOP AND MANAGE RESOURCES TO SERVE THOSE IN GREATEST NEED. INSTEAD THE ACT'S UNLIMITED LIST OF FUNDABLE SERVICES LED MANY SERVICE PROVIDERS TO FEEL THAT THE ACT WAS AN ENTITLEMENT PROGRAM FOR ESTABLISHED PROVIDERS. MEANWHILE, THE LARGEST PROGRAMS IN THE ACT, NUTRITION AND EMPLOYMENT, REMAINED CATEGORICAL, LENDING CREDENCE TO THE VIEW THAT THE CAUSE OF THE FRAIL, VULNERABLE ELDERLY WAS NOT AS PRESSING AN ISSUE.

OVER THE PAST DECADE, AREA AGENCIES ACROSS THE NATION, TRUE TO THE INTENT OF THE ACT, HAVE INCREASINGLY FOCUSED ON THOSE STRUGGLING TO STAY IN THEIR OWN HOMES. WE HAVE LEARNED THAT THESE VULNERABLE PEOPLE ARE OLDER, SICKER, POORER, AND MORE ISOLATED THAN OTHER ELDERS. MOST OFTEN THEY ARE STRICKEN WITH A DISABLING CHRONIC DISEASE AT A TIME WHEN PENSIONS HAVE LOST THEIR PURCHASING POWER. MANY ARE WIDOWS WITHOUT WORK HISTORIES WHO ARE NOT ELIGIBLE FOR THEIR HUSBANDS' PENSIONS. MORE THAN HALF OF THE ELDERLY SERVED BY AREA AGENCIES ARE 75 AND OLDER. MOST HAVE TROUBLES OTHER THAN THEIR DISABILITIES, INCLUDING MALNUTRITION, DEPRESSION, AND INTENSE LONELINESS, AS WELL AS, HOMES IN DISREPAIR, NEED FOR HOMEMAKING HELP, AND CHORE SERVICES. BECAUSE THEY ARE INVISIBLE, THEIR NUMBERS ARE GROSSLY UNDERESTIMATED.

WE HAVE LEARNED, AND RESEARCH HAS SUBSTANTIATED, THAT WHILE NURSING HOMES ARE CONSIDERED HEALTH CARE INSTITUTIONS, HEALTH CARE IS NOT THE PRIMARY REASON FOR PEOPLE TO GO INTO NURSING HOMES. THE PRIMARY REASON IS DIFFICULTY WITH ORDINARY ACTIVITIES OF DAILY LIVING AND THE LACK OF AFFORDABLE SUPPORTIVE SERVICES IN THE HOME TO MAKE THE ACTIVITIES OF DAILY LIVING POSSIBLE. WHILE AN ELDERLY PERSON MAY NEED CONTINUING HEALTH CARE AFTER BEING DISCHARGED FROM A HOSPITAL, THE NEED FOR THE HEALTH CARE USUSALLY DIMINISHES IN A FEW MONTHS. BUT IF HOME SUPPORT SERVICES ARE NOT IN PLACE, AN ELDERLY PERSON MAY LIKELY BE A CANDIDATE FOR A NURSING HOME. SIGNIFICANTLY, WHEN HEALTH CARE ELIGIBILITY RUNS OUT, THE BURDEN OF CARE FALLS MOST FREQUENTLY ON TITLE III-B OF THE OLDER AMERICANS ACT, THE MOST NEGLECTED PORTION OF THE ACT.

IN SEVERAL STATES, STATE UNITS AND AREA AGENCIES ON AGING HAVE DEVELOPED SOLID SYSTEMS SERVING THE VULNERABLE ELDERLY, DRAWING IN OLDER AMERICANS ACT, SOCIAL SERVICES BLOCK GRANT, MEDICAID, MEDICARE AND/OR STATE REVENUES, INTEGRATING THEM THROUGH CASE MANAGEMENT ACTIVITIES. WE WERE PLEASED THESE MODELS RECEIVED RECOGNITION FOR SUCCESS THROUGH THE CONGRESSIONAL MANDATE OF THE 1984 REAUTHORIZATION INSTRUCTING AREA AGENCIES TO "FACILITATE THE COORDINATION OF COMMUNITY-BASED LONG-TERM CARE SERVICES...TO EMPHASIZE THE DEVELOPMENT OF CLIENT-CENTERED CASE MANAGEMENT SYSTEMS AS A COMPONENT OF SUCH SERVICES".

IN A PERIOD WHERE WE SEE MAJOR GROWTH IN OUR "OLD-OLD" POPULATION, MAJOR CHANGES IN THE MEDICARE PROGRAM ARE PLACING NEW STRESSES ON THE COMMUNITY CARE SYSTEMS. RAPID GROWTH IS OCCURRING IN THE ENTIRE HEALTH CARE MARKET WITH NEW PROVIDERS GRASPING FOR A PIECE OF THE ACTION. IT IS NO WONDER OLDER PERSONS

AND THEIR CARE GIVERS FIND OUR ENTIRE HEALTH AND COMMUNITY CARE SYSTEMS A CONFUSING MAZE TO WORK THROUGH; THE GROWTH OF COMMUNITY-WIDE CASE MANAGEMENT SYSTEMS HAS BEEN VERY IMPORTANT TO THE ELDERLY IN THESE CONFUSING TIMES.

SINCE THE IMPLEMENTATION OF DRG'S IN THE 1980'S, AREA AGENCIES ON AREA AGENCIES ON AGING HAVE EXPERIENCED TREMENDOUS GROWTH IN THE UTILIZATION OF THEIR SERVICES. AGENCIES REPORT THAT THEY ARE SPENDING A DISPROPORTIONATE PERCENTAGE OF THEIR FUNDS ON SERVICES FOR THE FRAIL HOMEBOUND PERSON. THESE INCREASES REFLECT NEW DEMANDS ON THE COMMUNITY-BASED AND IN-HOME SERVICES PROVIDED BY THE AREA AGENCIES UNDER TITLE III-B OF THE OAA. A MAJOR QUESTION THAT NEEDS TO BE ASKED DURING THIS REAUTHORIZATION IS: DO WE INTEND FOR THE OLDER AMERICANS ACT TO SUPPLEMENT MEDICARE THROUGH HOME CARE AND SUPPORT SERVICES AND IF SO, HOW, WITHOUT ADDITIONAL FUNDS TO MEET THE NEW DEMANDS? WE RECOMMEND THAT A MERE 1% OF THE SAVINGS RESULTING FROM THE MEDICARE COST CONTAINMENT MEASURES OF DRG'S BE TRANSFERRED FOR HOME AND SUPPORTIVE SERVICES UNDER THE OLDER AMERICANS ACT.

I HAVE PURPOSELY OUTLINED SOME CRITICAL POINTS IN THE HISTORY OF AREA AGENCIES THAT DEMONSTRATE OUR ABILITY TO BE A RESPONSIVE AND STRONG NETWORK. WE LOOK TO YOUR COMMITTEE TO CONTINUE TO SUPPORT THE SUCCESSES OF OUR NETWORK, BUT ALSO TO ASSIST US IN STRENGTHENING IT THROUGH THIS REAUTHORIZATION. WE ARE SEEKING CONTINUED FLEXIBILITY TO DETERMINE THE NEEDS OF OUR LOCAL COMMUNITIES, TAKING INTO CONSIDERATION NOT ONLY THE GROWING NUMBER OF ELDERLY PERSONS WHO HAVE UNMET NEEDS, BUT ALSO THE SUPPLY AND DEMAND OF OUR SERVICES AND THE COMMUNITIES RESOURCES WHICH ENABLE US TO SUPPORT THOSE CRITICAL SERVICES. WE CONTINUE TO OPPOSE THE STATE BLOCK GRANT APPROACH; IT DOES NOT PROVIDE FOR DECISION MAKING AT THE COMMUNITY LEVEL, AND IT DIFFUSES RESPONSIBILITY AND WEAKENS ADVOCACY.

WE WANT TO MAINTAIN A STRONG NETWORK AT THE FEDERAL, STATE AND LOCAL LEVELS. THE ADMINISTRATION ON AGING NEEDS TO PROVIDE THE LEADERSHIP FOR THIS NETWORK. THE COMMISSIONER NEEDS TO HAVE THE AUTHORITY TO COLLABORATE WITH OTHER FEDERAL AGENCIES WHICH ASSIST US IN BUILDING THE BRIDGES WHICH WE MUST CROSS AT THE LOCAL LEVEL. FOR EXAMPLE, STRONGER RELATIONSHIPS ARE NEEDED WITH THE DEPARTMENTS OF TRANSPORTATION AND HOUSING TO BETTER ENABLE US TO ADDRESS THE CRITICAL NEEDS AT THE LOCAL LEVEL. WE CONTINUE TO BELIEVE THAT AOA'S STRENGTH CAN BE BETTER ACHIEVED ONLY IF THE COMMISSIONER IS AT AN ASSISTANT SECRETARY LEVEL OR AT THE LEAST, REPORTS DIRECTLY TO THE SECRETARY OF HEALTH AND HUMAN SERVICES RATHER THAN BE BURIED WITHIN THE OFFICE OF HUMAN DEVELOPMENT SERVICES.

STRENGTHENING THE NETWORK AT THE LOCAL LEVEL CAN BE ENHANCED BY ENCOURAGING THE FURTHER DEVELOPMENT OF OUR COMMUNITY BASED LONG TERM CARE SYSTEMS. NAAAA IS SEEKING TO STRENGTHEN THE ROLE OF THE FINANCIALLY "DISINTERESTED" AREA AGENCY ON AGING IN MANAGING AND BROKERING SERVICES THROUGH CASE MANAGEMENT. WE CONTINUE TO EMPHASIZE THE IMPORTANCE OF THE ADVOCACY ROLE OF THE AREA AGENCY, REPRESENTING THE INTERESTS OF OLDER AMERICANS BEFORE LOCAL, STATE, AND FEDERAL DECISION MAKERS.

THE AREA AGENCIES HAVE TAKEN SERIOUSLY THE NEED TO WISELY USE LIMITED RESOURCES. WE HAVE TIGHTENED SERVICE DELIVERY BY TARGETING WHERE POSSIBLE; WE UTILIZE THOUSANDS OF VOLUNTEERS IN CREATIVE WAYS; WE HAVE MOVED TO MANAGE OUR PROGRAMS MORE EFFICIENTLY THROUGH COMPUTERIZATION; AND WE HAVE IMPLEMENTED SUPPORT GROUPS TO EXPAND THE USE OF FAMILY AND NEIGHBOR CARE GIVERS. WE ARE NOW OPERATING WITH MINIMAL RESOURCES COMPARED TO DEMAND. THE TIME MAY BE NOW

TO CONSIDER INCREASED COST SHARING BY PARTICIPANTS FOR SERVICES WHEN POSSIBLE. WE ARE SEEKING A MECHANISM TO ESTABLISH VOLUNTARY COST SHARING WITHOUT TRANSITIONING THE PROGRAM TO A MEANS TESTED PROGRAM.

MUCH ATTENTION HAS COME TO THE OMBUDSMAN PROGRAM AS A RESULT OF CHANGES IN THE MEDICARE AND MEDICAID PROGRAMS. WE SUPPORT EFFORTS TO STRENGTHEN THE AUTHORITY OF THIS PROGRAM, UNDER THE OLDER AMERICANS ACT, AND TO ENHANCE ITS ROLE WITHIN THE STATE AND AREA AGENCY NETWORK. WE CANNOT FURTHER ENHANCE AND EXPAND THIS PROGRAM HOWEVER, AT THE EXPENSE OF OTHER TITLE III-B SERVICES. WE ARE THEREFORE SEEKING NEW APPROPRIATIONS UNDER A SEPARATE TITLE FOR THE OMBUDSMAN PROGRAM.

ENACTED MEASURES TO PERMIT MEDICARE AND MEDICAID TO SUBSIDIZE HEALTH CARE IN THE HOME HAVE CREATED ANOTHER PROBLEM: MAJOR GROWTH IN THE HOME CARE INDUSTRY. WHEN A SINGLE LOCAL HOME HEALTH SERVICE PROVIDER OPERATED A MODESTLY FUNDED PROJECT, THERE WAS LITTLE POTENTIAL FOR ABUSE. BUT TODAY COMPETITION IS KEEN, AND PROVIDERS TURN ON THE HARD SELL FOR CLIENTS. SOME PROVIDERS HAVE MUCH PROFESSIONAL INTEGRITY, BUT OTHERS ARE EXPLOITIVE. WE HAVE SEEN EXPANSIVE HEALTH CARE PROVIDED WHERE MUCH LESS EXPENSIVE SOCIAL SUPPORTIVE SERVICES, OR EVEN TRAINED FAMILY MEMBERS, COULD ADEQUATELY PROVIDE THE NEEDED SERVICES. THIS OVER-UTILIZATION IS A PRODUCT OF A POORLY MONITORED AND MANAGED SYSTEM. FREQUENCY AND DURATION OF SERVICE FOR CAPTIVE CLIENTS CAN BE SET BY THE PROVIDERS, WHO IN TURN PROFIT FROM THE SERVICE DELIVERY.

HOME CARE SERVICE IS FUNDED WITH LESS UTILIZATION REVIEW AND MONITORING THAN NURSING HOMES, AND THE POTENTIAL FOR ABUSE EXISTS. CONSIDERING THE ROLE

OF THE AREA AGENCY ON AGING TO ADVOCATE ON BEHALF OF CLIENTS IN THE CASE MANAGEMENT AND OMBUDSMAN PROGRAMS, AS WELL AS THEIR MANDATE TO MONITOR SERVICES WITHIN THEIR PLANNING AND SERVICE AREA, WE SUPPORT THE DEVELOPMENT OF A ROLE FOR THE AGING NETWORK IN THIS CRITICAL ADVOCACY PROCESS. TO MEET THIS INCREASED RESPONSIBILITY, A SEPARATE SUBSECTION OF THE NEW OAA TITLE-IIID, REFERENCED EARLIER, MAY BE IMPORTANT TO CONSIDER.

THE AGING NETWORK IS A PROVEN AND EXISTING NETWORK THAT COVERS THE ENTIRE COUNTRY. WE ARE THE LOGICAL ENTITY TO ASSUME SOME OF THESE NEWLY PROPOSED RESPONSIBILITIES. BUT, NOT AT THE EXPENSE OF THE ORIGINAL INTENT OF THE OLDER AMERICANS ACT, THAT IS, TO ASSIST OLDER PERSONS TO REMAIN IN THEIR COMMUNITIES AND HOMES. WE THEREFORE, ARE SEEKING YOUR SUPPORT TO ASSURE THE INTEGRITY OF THE CURRENT TITLE III-B PROGRAMS AND TO ASSIST US IN FINDING NEW OR TRANSFERRED FUNDS, WHETHER THEY ARE FROM MEDICARE, MEDICAID, OR PUBLIC HEALTH TO SUCCESSFULLY FULFILL THESE ROLES.

WE SHOULD NOT LISTEN TO DISCUSSIONS ABOUT REDUCTIONS IN SERVICES FOR NEEDY OLDER PERSONS, RATHER WE SHOULD BE PLANNING FOR RESPONSIBLE WAYS TO SUPPLY EVEN MORE NEEDED SERVICES TO THIS DRAMATICALLY EXPANDING POPULATION. WE CANNOT ALLOW CHANGES IN PUBLIC POLICY TO ERODE A VERY LIMITED SUPPORT SYSTEM FOR NEEDY OLDER PERSONS. WE NEED THE CONTINUED SUPPORT OF YOUR COMMITTEE TO MEET THESE CRITICAL CHALLENGES UNDER THE OLDER AMERICANS ACT.

Mr. **Kildee**. Thank you, Mr. Proffitt. I have some questions, some directed to specific members and some in general.

Ms. Duson, in your statement you express a specific need for statutory language that would ensure access to facilities and to certain records. Could you expand a little on the types of problems ombudsmen are facing that would make that language necessary?

Ms. **Duson**. Yes, sir. We are speaking of access in a couple of areas. One is the threshold issue of access to the facilities that we cover. Some state ombudsman programs have difficulty gaining access to facilities in other than ordinary visiting hours of nine to five. From time to time, is it necessary to conduct an investigation on an issue of understaffing on the night shift, for instance, that you cannot possible validate without entering the facility to count heads during the shift when the problem is occurring.

Secondly, the issue of access to residents' records has been a problem for most state ombudsman programs in the area of acces to the records of residents who are arguably incompetent but who do not yet have guardians. In Maine and I believe three or four other states, we have specific state language which permits access to those records but limits our right to copy unless we white-out the resident's name in order to carry forward with an investigation. But many other programs have difficulty gaining access to records to just about any resident of a nursing care facility because there is a presumption of incompetency by the very virtue of their residency in the facility.

Lastly, the access issue with regard to documents developed by the state survey agencies is specifically not only the annual survey, the statement of deficiencies and plan of correction which is available to anybody perhaps nine months to a year after the survey has occurred, but additionally, the investigation reports which the state agencies are required to develop under—regulations have generally not been available to ombudsman programs even if those investigations were conducted in response to complaints referred by our programs.

Mr. **Kildee**. What in general has been your experience as to the attitude of the providers when you come in and discharge your responsibility as ombudsman? Is there high cooperation, moderate cooperation or even some resistance?

Ms. **Duson**. I think that the committee members might be surprised to hear me say that there is usually good cooperative attitude. I think that there is a expected defensive reaction when you actually arive at the threshold. There is a wondering, what are you here about? And what are you going to do to me? But I think that most programs, most ombudsman programs have been around long enough and the state associations of nursing home owners have been interacting with ombudsman programs long enough so that there is a mutual respect and in most instances there is not a problem in terms of cooperativeness once an investigation is started.

Mr. **Kildee**. Here is a question that any or all of you may respond to.

Given the increasing number of elderly who do not have extensive health care needs as such but who do need in-home assistance to a certain activities of daily living, would you support new authorization, in addition to III-B, to support in-home help to those frail elderly. I have proposed a $25 million new authorization. Would you care to comment on that?

Mr. PROFFITT. Yes, I would like to comment on that. We would be very supportive of that type of authorization, but we would like to see it under Title III-B and possibly as a designated service under Title III-B. We feel that the need for management in coordination of services is as vital as the need for the actual service itself.

The Federal Government is not the only funding source for in-home services. State and local governments as well as the funds that come from the participants themselves are also needed. And we feel that for those moneys to be channeled down to the local community other than through an expansion of Title III-B might put more of an emphasis on the actual service delivery and add to the proliferation of the services rather than bring it about in a coordinated comprehensive fashion.

Mr. KILDEE. You stress the management aspect a great deal and that it is very important that we—in any of our programs, that we keep that in mind then.

Mr. PROFFITT. Yes, I believe that there has been a mindset in America for a long time on the medical model of services and as Mr. Bechill pointed out earlier, that mindset, I believe, resulted from the majority of Medicare and Medicaid dollars going into institutional care.

Now, the community based care is a long term care approach that we are having a very difficult time communicating that we need not just the services but a comprehensive approach to managing those services on specific individuals. Right now, many services can exist, but if without that case management, it puts the onus of responsibility on the client to go out and find all those services and work through that maze. And that is really what we are trying to overcome.

Mr. KILDEE. From a management point of view, it is one person with a variety of needs that you are looking at, right?

Mr. PROFFITT. Right. In Iowa, for instance, we are experimenting with case management model in my own agency where—we are saying that a person who has a functional disability and who needs three or more services from different agencies should be eligible for what we call our Assessment and Case Management Program.

We are not talking about managing all older people. We are talking about only those frail and vulnerable who will end up being managed in nursing homes if they are not given this care management with a care plan developed based on their personal individual needs.

Mr. KILDEE. Does anyone else have a comment on that authorization for the frail elderly?

Ms. MCDOWELL. I am confident that my colleagues would agree that state directors of state units on aging would support any effort to increase resources for in-home services. We are certainly struggling at the state level, as I know you are at the federal level, to address the incredible imbalance between the enormous amounts of money going into institutional care which most older folds do not want and the much more modest levels of funding going into in-home services for which older people express an overwhelming preference. We have a peculiar bias that works against what older people have been telling us for years they want. Now that we have begun to develop effective in-home service programs, learning how to manage the multiple programs and funding sources, older people have developed confidence in in-home services. They want them. They know that there are alternatives to nursing homes, and we are in a tremendous bind in terms of our resources to meet that growing demand—which is, I might say, why we introduced the unpopular topic of cost-sharing as well.

Mr. **KILDEE**. Any other comments?

All right, Mr. Tauke.

Mr. **TAUKE**. Thank you, Mr. Chairman.

Since you have the microphone—is it Ms. McDowell?

Ms. **MCDOWELL**. Sure.

Mr. **TAUKE**. Since you have the microphone, let me start with you, if I can get my statements in order.

You indicated that in Wisconsin you have established a program which you call the Community Options Program.

Ms. **MCDOWELL**. That is right.

Mr. **TAUKE**. Is this something that we should be looking at adopting on the federal level or encouraging other states to adopt, as you have? It sounded intriguing.

Ms. **MCDOWELL**. I think that there are a number of features of the Community Options Program which would be of interest to the Members of Congress and the federal agencies. As I indicated, one of those features is that we have promoted the program as being available to all persons regardless of income because we are aware of the fact that middle and upper income people cannot figure out how to get in-home care. The maze of agencies and programs out there is too confusing. They understand nursing homes, turn to nursing home care, and we feel that it is important to offer good assessments and good case plan advise to people regardless of income. But then we do have cost-sharing based on peoples' ability to pay and, as I indicated, fully a quarter of our people in our case load are paying the full cost of care.

But we do offer at no charge the initial case assessment and case plan and we cost out for the individual or their families what the cost would be of a variety of services. We introduce them to the range of providers of those services that would be available in their community and we require, by our state rules, that the decision about the program be left to the individual—that is, we do not prohibit anyone from entering a nursing home if they are eligible to do so, even if community care is feasible, but we do try to describe to the individual and their family how community care would work for that person. What we find is that people, even if they have to pay the full cost, overwhelmingly choose community care when they understand how it will work, when they understand how it relates to their very specific needs.

Mr. **TAUKE**. You are speaking here of what kinds of in-home services?

Ms. **MCDOWELL**. Well, one of the features of the Community Options Program is that by our state statute we will pay for anything that is needed that is identified in an assessment and care plan, which can include home modification, it can—we will pay for 24-

hour around the clock attendant care or for respite care two hours a week if there is an in-home care giver.

Mr. TAUKE. Nursing care?

Ms. McDOWELL. We do not pay for those services that are available to the individual under other funding sources, whether it is their private insurance or Medicare or medical assistance in that case. But in evaluating our program, we have considered all public sources of funding, including Medicare and Medicaid, and we have found that community care has been less expensive in terms of public dollars than institutional care.

Mr. TAUKE. If I am elderly citizen, 61 years old, and I have a problem, a health problem, I come to your agency for help. Is this the case management kind of thing that Russ Proffitt was talking about?

Ms. McDOWELL. That is right.

Mr. TAUKE. You put a package of services available together that might be available for me?

Ms. McDOWELL. That is right, we——

Mr. TAUKE. And then I can choose from that package of services. You would pay for some or you would look to other resources to pay for those services as well.

Ms. McDOWELL. That is right. We—I should say that we assess not only what the needs of that individual are but what their resources are, where they live, how suitable their living arrangement is, we look at the presence of family care givers and other informal supports, we look at what those family care givers may need in terms of respite. We do a really comprehensive assessment and then identify what is available from other funding sources and we, like Maryland, refer to our Community Options Fund as a gap filling source of funds.

We do not put any limits on how much the state will support on a case by case basis in terms of the support of the individual, but we do set, as a state, an average that our county governments who administer the program must maintain over the case load.

Mr. TAUKE. Can you send us additional information on this program?

Ms. McDOWELL. I would be delighted to. I might mention that an enormous number of states have developed similar programs, often with the use of the Medicaid home and community based waivers, often with state funds. I think Wisconsin is unique both in terms of the size of our program for a state our size and the fact that we did it entirely with state funds. Frankly, we did so in order to avoid a lot of the entanglements of Medicaid.

But this type of assessment case management program is not unique and I do not want to give the impression that only Wisconsin has it.

Mr. TAUKE. Without the state program, would you be able to have case management for the 61 year old that I described?

Ms. McDOWELL. Without case management, we would be able—without the Community Options Program, we would be operating assessment and case management programs primarily under the Medicaid waiver options. We would be serving far fewer older persons because so many older people in Wisconsin are not income eligible for medical assistance. We have a much more liberal income threshold for our Community Options Program. We will pay the full cost of services for someone who has an income level that they would not spend down for six months in a nursing home. We also have a much more liberal asset test than medical assistance does. So, a lot of what we are doing with state money we could not do with federal money for a particular income range of older persons, except with the very limited amount of Title III-B that we have—and we would be using Title III-B for this kind of service. But as I indicated, we get about $5 million of Title III-B and we have a $25 million state program. III-B just would not meet the need that our state program is meeting.

We are hoping that increasing flexibility in medical assistance would enable us to use—have more federal participation in our programs and we also hope that Congress will be looking seriously at the restrictions in the Medicare program for home health services, all of which would substantially help us in this endeavor. But we have had to depend a great deal on our state funding because of the problems that medical assistance and Medicare have given us.

Mr. TAUKE. Do any of the rest of you want to comment on this kind of program, and is it the way to go to meet this need? Or is it preferable or different from what Congressman Kildee has put in his proposed legislation? Yes?

Mr. PROFFIT. Well, as I tried to say earlier, I think we need to recognize that we need a combination of funding sources—federal, state, and local. It is our understanding that well over 50 percent of the people who enter nursing homes as full pay persons in less than six months end up on Medicaid. Now we approached Medicaid in Iowa, for instance—our state association contracted $15,000 to the Department of Human Services, who is responsible for Medicaid, to write a Medicaid waiver. And what we wanted in that Medicaid waiver was for Medicaid for those who are eligible to receive assessment and case management services, adult day care, respite, and in-home mental health services.

We worked for a year in developing that Medicaid and then the Medicaid waiver program for new states or new issuances came to a halt. So, we were back at square one.

What we are talking about, and we are doing in Iowa— the Governor, for instance, has proposed in his budget message this year $250,000 for two to four models of assessment and case management to bring to bear the federal funds, what we call in Iowa the state's Elderly Services Program, which funds adult day care and some of these other services with state dollars—so we are talking now of a beginning. But it is going to take federal funds, it is going to take state funds—and in my own county, which is the only county in Iowa that, at this point, has a functioning case management program—our case manager coordinator is paid for by county funds because there are no other funds available.

Mr. TAUKE. You probably get the hint, if you are listening this morning, that there is a very strong likelihood, in my view, that something on in-home health services is going to be in this act. I think several of us are very interested in doing that.

It occurs to me, though, that we have primarily two questions to ask. The first is where to put it and how to structure it, and the second is whether it should be focused toward the providing of services, the direct providing of services or the management of those services.

You obviously are pretty interested in focusing on the management side, that we need the case management.

Mr. PROFFITT. Well, I am interested in three things. One, it should be in our opinion channeled and organized through Title III-B as other human social services are in the Older Americans Act now. Number two, it should be contingent upon—the service should be contingent upon an assessment and case management program, just to throw out more services, we are saying, and those services are needed. But just to throw out more services, it is going to be a bottomless well, we believe, and so the two have to be tied together, we believe. And number three, they should be tied together, we velieve, at the area agency level, channeled through the state, as Title III-B is now, but they should be tied at the local level.

Mr. TAUKE. Anybody differ with that?

Ms. McDOWELL. I think the only point that I would make, and I do not think that it probably matters whether it is a separate title or part of Title III-B—we manage so many funding sources already that we can keep track of another—our accountants can keep track of another line.

Mr. TAUKE. Would it be brought together when you get down to the state and local level?

Ms. McDOWELL. Right. I think if it is your interest to give additional visibility to this program, it makes a lot of sense to separate it. If it is part of III-B, we can assure you that it will go to in-home services which is where our great demand is.

I would say, though, that in determining whether it ought to go to case management or services, I would hope you would defer to the states to make those decisions because, as I have indicated, states are developing home and community based care programs. In some cases, states or even county governments have invested heavily in the services but there is a need for a strong management component which is absent, as Russ might indicate in Iowa.

In other states, the—there has been a significant investment in the case management and overall services management effort, such as in Pennsylvania and in Wisconsin, I think, which have highly developed pre-existing case management systems. In those cases, I think the states would tell you that their strong need is for the actual additional units of service. So, I would hope that there could be sufficient flexibility for states to determine, based on what already exists, where the need is.

Mr. TAUKE. Yes?

Ms. DUSON. I just wanted to interject quickly that the state of Maine also has a comprehensive state funded in-home service—in-home case management system. One issue I wanted to raise is that our state is now on the verge of defining case management as a service which would be paid through under our state program—paid for under our state program and is currently reimbursed under Medicaid waiver services. The reason I——

Mr. TAUKE. Which—Maine? Okay.

Ms. DUSON. Maine. The reason I raise that is in the context of a advocacy system for people who now receive those services either through a private home health agency or care management services through an area agency that it is important not to tie both the provision of services and the quality assurance of those services into the same site.

Mr. **Tauke**. Mr. Chairman, I have gone way over my time limit; and I just want to thank this panel. I had several more questions for each of you but I want to thank you for throwing out a lot of new ideas and raising some issues that I think will be very helpful to us.

Mr. **Kildee**. Mr. Biaggi?

Mr. **Biaggi**. Thank you, Mr. Chairman.

Ms. Duson, on page five, on number—on the bottom of the page, you talk about protection from liability for the programmer's designees while engaged in good faith performance of official duties, and I think you may have made reference also, Ms. McDowell. How serious a problem is that? Can you give us an example or two?

Ms. **Duson**. I think we will have a much better hand on that after the—there is a survey of ombudsman programs that has been developed through the American Association of Retired Persons with input from quite a number of national aging organizations, and that is an area that is being asked. How many programs have actually been either threatened with law suit or sued, how many volunteers within those programs have had the same kind of activities?

I know that in our state we have been approached by or threatened with liable actions and other kinds of issues. We have language in our state statute that covers us from liability. Many programs do not have strong state language that addresses that issue. Most programs have tried to get it and it failed.

And it is a really important issue in terms of getting consumer involvement in ombudsman programs. If they feel that they are in danger of losing all their personal assets by advocating on behalf of a frail older person, it can be a very chilling effect.

Mr. **Biaggi**. I think it be important for this committee to have as much backup material as possible for us to seriously consider that. I can see where it can be a problem.

Ms. **Duson**. I will make sure that the results of the survey are turned into the staff director.

Mr. **Biaggi**. On page 6, you have a number of other recommendations. Are these recommendations based on ongoing problems that you are now facing?

Ms. **Duson**. I am sorry, let me find page 6 please.

Mr. **Biaggi**. Top of the page.

Ms. **Duson**. I am sorry, my numbers are hidden.

Mr. **Biaggi**. That follows the—you have a series of these things, protection liability, then you go over—that is number one, then you go to two, to——

Ms. **Duson**. Yes, in quite a number of states including Maine, we have had individuals who have filed complaints with the ombudsman program who happen to work in nursing care facilities, be fired or have been threatened with being fired. The whistle-blower protection addresses that issue.

Almost all of these come particularly out of specific experiences within the state programs. The penalty for interference is the issue where we have a staff person in the facility when we arrive who is willing to cooperate with the questions raised by the office but the higher-ups within the facility tell them that they have to screen their answers through the administrator or the owner.

The only issue I would say that has not been—that is kind of—is more an issue of the potential problem than it is an actual problem—is the conflict of interest restrictions on placement of the ombudsman office within the state structure. There are a handful of states that have had those kinds of problems and a—some federal language on that issue would be very helpful. It is impossible for those states to advocate for themselves, in their own environment.

Mr. **Biaggi**. Again, would you provide us with some backup material?

Ms. **Duson**. Certainly, sir.

Mr. **Biaggi**. Be more detailed and elaborate.

Ms. Felcher, second page of your testimony, what restrictions are there that eliminate minority participation?

Ms. **Felcher**. Would you repeat your question again? I was looking for the second page.

Mr. **Biaggi**. Yes, how do restrictions and what restrictions are there that eliminate minority participation?

Ms. **Felcher**. The age restriction is the biggest. We find that—as I stated in my testimony—that if we could open up the doors to people 55 years of age and older, that we would be able to outreach the community and bring in those folks, those minority folks.

Mr. **Biaggi**. Yes, I appreciate that. If we lower the age, we can lower it and lower it and lower it. But I understand what you are trying to do and I do not mean to be——

Ms. **Felcher**. No, it is okay.

Mr. **Biaggi**. But, that is just the age restriction?

Ms. **Felcher**. Yes, well——

Mr. **Biaggi**. Well, do not you feel that we have a—do you believe that we have done enough to reach out? We have a minority age population. They are there and they would like to participate. I know, because they do participate, and I see them and you see them.

Ms. **Felcher**. As you know, Congressman, I have been around the nutrition program for a long time, and I was sitting here thinking, since 1975. In the good old days, when we did outreach, we went into the community, knocked on doors, spoke at church groups, spoke at community meetings, we had staff to do that. But through the years, our funding has been erroded to make sure we got the meals out. And our outreach efforts have—are almost nil now. Well, I used to be the Director of Eating Together in Baltimore, that Professor Bechill spoke of. I used to have 50 people on my staff at one time. Eating Together is a big program and we have 75 nutrition sites in the city alone. And those people were—their job description read community outreach. Those people are no longer on my staff.

If we do outreach, it is hit and miss, and I am not proud to say that but that is because of the financial constraints that we have been under.

Mr. **Biaggi**. You finally gave me an answer that I was looking for.

Ms. **Felcher**. Sorry.

Mr. **Biaggi**. No, you gave me an answer that I have been looking for. We keep asking people about outreach. The bottom line is——

Ms. **Felcher**. There is no outreach in Baltimore.

Mr. **Biaggi**. You do not have recruits.

Ms. **Felcher**. That is right.

Mr. **Biaggi**. We have outreach in legislation, we have it in all of the—all of our discussions, but we do not have an outreach mechanism that is equal to the occasion.

Ms. **Felcher**. That is right. Word of mouth has been to date, since the demise of our outreach units, the thing that brings the most folks into the program.

Mr. **Biaggi**. Well, but it focuses very sharply on the fact that we need funding for outreach efforts.

Ms. **Felcher**. Absolutely.

Mr. **Biaggi**. I mean, that is it, pure and simple. I was wondering why you distinguish minorities from others. Minorities want to get out there if you let them know that it is there.

Ms. **Felcher**. That is correct.

Mr. **Biaggi**. Well, if you got back to your 50 staff, I am sure you would have all the minorities you wanted.

Ms. **Felcher**. I would like to get back to 35 or 40.

Mr. **Biaggi**. Well that is—finally I got an answer.

Ms. **Felcher**. Okay.

Mr. **Biaggi**. Mr. Chairman, that is where it is at. I think that by lowering the age, I understand why you want to do it. I am not quarreling with you. But I think that would—number one, I do not think it would pass. But number two, I think it would create a whole panoply of problems.

But aside from that, further down on that page it says, "we would like to offer the programs to serve clients that we assess." Would this mean nutrition directors or area agency people or both?

Ms. **Felcher**. Nutrition project directors—we are the people who are out there every day speaking to the people, doing intake at the site level. We can see first hand basis who is coming into the programs. In all due respect to area agencies—and I am right now part of an area agency—that is an administrative tool. The nutrition project directors and site managers are out there fighting the daily battles and meeting the people one to one.

Mr. **Biaggi**. You further go on saying, acknowledging that "participants in our program could contribute more to offset the cost of providing services..." Is there any data to support the idea that those with more resources pay more when asked?

Ms. **Felcher**. I do not know of any data, it is probably more anecdotal than anything else. I can really only speak from Baltimore and hearsay from other nutrition project directors—because of the way the program got off the ground in some locations, people are not paying—some people are paying a lot less—contributing a lot less than other people. In Baltimore, there are folks who contribute a quarter and there are persons who contribute a dollar 25, and there are some who pay—who contribute the entire cost of the meal. Somewhere between that, there should be a way of people paying their fair share.

Mr. **Biaggi**. Why the disparity?

Ms. **Felcher**. It is a disparity because of the way the program was presented in certain communities and the way it was not presented in other communities.

Mr. **Biaggi**. You make reference to creative—aging networks should creatively look for methods of utilizing sliding-scale donations. How do you distinguish this between—how do you—what is the distinction between this and the means test?

Ms. **Felcher**. It is a very fine line, I know. And this position paper comes—this testimony comes from a position paper presented by the entire membership of NANASP.

There are some projects across the country that are doing sliding-fee scales right now and it is a—and my understanding is that when a participant comes into the site, there is listed on the table or on a wall—if your income is such and such then it would be good if you could contribute *x* amount. Nobody is forcing you, it is a purely personal contribution, a suggestion, not a means test. That is between the person—a personal decision that the person makes, whether they fit in that sliding-fee scale.

Mr. **Biaggi**. The following page, you say, no matter "We continually produce more units of service" each year, "But the fact is we are still reaching only a small percentage of the seniors that need our nutrition services," you have any specific percentage at this moment?

Ms. **Felcher**. I can give you Baltimore's percentage, and that is a pretty good statistic, I think. There are 140,000 seniors in the city of Baltimore. Last year, the unduplicated numbers of persons coming into nutrition sites was a little over 16,000. And I do not think we are any different than any other place in the country.

So, you can see, it is just miniscule. And I do not believe that everybody needs nutrition services, either. I mean, there are folks who do very well on their own.

Mr. **Biaggi**. You also say, "The transfer of funds should be limited to not more than 15 percent from any one title to another." And we agree with you on that. Would you keep the overall level now at 30 percent, in effect?

Ms. **Felcher**. Not at all. Statistics are showing that they are only taking—transferring 18 percent out.

Mr. **Biaggi**. All right, thank you. Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you. Mr. Grandy?

Mr. **Grandy**. Thank you, Mr. Chairman.

Mr. Proffitt, I think I will begin with you. I have read your testimony and I was a little curious to find out if over on your side of the state you have run into any conflict with the area agencies—a conflict between the private sector, insurance companies, and many area aging groups that are now selling low cost insurance. Have you had that problem?

Mr. **Proffitt**. We have had a lot of serious conflict and problem with, for instance, supplemental insurance. We have had a continual string of complaints to the insurance commissioner, as a matter of fact now the new—we have a new insurance commissioner who is, as a result of the disproportionate number of complaints coming from senior citizens and questions on insurance—he is now sending staff into the field every other month into every area of the state to try to deal face to face with senior citizens with those problems.

We were privileged to have our first visit and with very little publicity, I think we turned out something like 80 or 90 people who came with their policies and with their questions.

Mr. **Grandy**. I agree with you totally. I believe there has got to be a lot of education in these matters, particularly with the need for expanded coverage and in the medi-gap area, and, if we move to some kind of federal catastrophic policy, finding out where the private sector can make up the difference. My concern is that in my area we have run into a potential conflict with area agencies selling insurance, and I wonder if there is a way to shortstop this potential for abuse right now.

Do you think that is an appropriate role, an appropriate service for the area agency to be involved in, to sell low cost insurance to the elderly?

Mr. **Proffitt**. Okay, we have one area agency in the state that is—that has, as a matter of fact, as a pilot project, moved into the area of trying to assist elderly in the screening of policies and then, as a matter of fact, as I understand it, is brokering what they regard as a good insurance medi-gap, insurance policy.

Mr. **Grandy**. Do you mean they are offering advice or they are offering a policy?

Mr. **Proffitt**. I believe they are offering advice. I am sorry I cannot produce an accurate comment——

Mr. **Grandy**. Would you feel as though you should be in the insurance business?

Mr. **Proffitt**. I do not want to be in the insurance business, no, per se.

I do believe, however, as I said earlier, there is a major problem for senior citizens trying to figure out—in fact, there—I would have to confess, I have numerous insurance policies, and to be as candid as I can be, a good many of them, when it gets right down to the bottom line, I have a hard time understanding them myself. And I think that is—I am typical, and it is especially difficult for senior citizens, and I believe——

Mr. **Grandy**. I think you could get unanimous consent in this room for misunderstanding insurance policies.

Mr. **Proffit**. Trying to address this this other way. But I really am not prepared to comment much on that because I really do not know the details.

Mr. **Grandy**. I think you offer a very valuable service up to the threshold where you are advising seniors on the ramifications of various policies and granted, they are complicated. I think that we would get into some danger if you start competing with the private sector here.

Ms. Duson, I wanted to ask you, to follow up on your proposed national study for state long term care ombudsman programs—and specifically, the place of the ombudsman as an independent advocate in the home care system. Is that what the focus of this study would be, assuming we provided the funds to have a national study, which I assume would be made up of various state models? Is that correct?

Ms. **Duson**. Yes, that is what the focus is—to address the need for a home care advocacy system by developing this system incrementally, much in the same way the long term care ombudsman system was developed—first putting out demonstration moneys and studying both the state's or local programs that win those demonstration moneys and the four or five states that are already covering home care consumers, which includes Maine, Wisconsin, Michigan, Minnesota, and I believe Virginia. I may be wrong on Virginia.

There are five state ombudsman programs already doing it. We are suggesting demonstration funding to pull in a couple of other different models which might not include the state ombudsman program, and then study what is the effect. Does it create a major diversions of efforts from institutionalize advocacy and therefore are there reasons not to go that way, and set up a different system?

Mr. **Grandy**. As hard as it is to get into an intermediate care facility or a skilled nursing facility, it would be even that much more difficult to get into a private home, would it not? How would that work—if you wanted to come in and exercise your authority or your participation as an observer? Do you have any thoughts about how that might work?

Ms. **Duson**. We have run into just that problem in trying to implement our recent expansion to home care ombudsman services. We are trying to revamp our policies and procedures. And specifically, what we found ourselves doing is being extra careful about making sure we have the consumer, the person who is actually receiving the service, mom, not the daughter or the son who is concerned but mom, signing on that permission to investigate form that says yes, come, I have a problem that I want you to look into.

But generally, what we have found so far is that the complaints that are coming to us are coming from the consumer, the consumer herself who——

Mr. **Grandy**. What kinds of complaints do you get?

Ms. **Duson**. Well, there are—they come in two different categories. If there have been a few that have had to do with the private home health agencies and the cost of their care plans, their failure to access the area agency system that would provide care management and perhaps come up with a cheaper care plan for that consumer. It is kind of—you cannot really expect the private sector to help the consumer look for the most inexpensive way of getting services.

On the other hand, we have had another perhaps five or six complaints that relate to the development of the care plan itself by the area agency, where choices have to be made based on limitations in the system that say "you, Mrs. Smith, are entitled to four hours of nursing services," and Mrs. Smith thinks she needs eight. Or your choice to stay home requires such a broad range of services at such a high cost that we make a decision not to provide you services under the care management system, then you have to wonder what recourse does the consumer have? And it is not that the—not that any parts of the system, I think, are badly intentioned, it is just—I think we have come from being a real good idea to trying to become a well managed program.

Mr. **Grandy**. That is my point. Obviously, this is an idea whose time has come, which means it is a burgeoning industry, and therefore there is a potential for abuse. The people that might suffer abuse would be those folks at home that might not understand a contract.

Do you see the need for some kind of regulation in this industry? Was the idea of your study to provide guidelines and avoid abuse?

Ms. **Duson**. I think that the—what we would hope for in the outcome of the study would be recommendations for the Administration on Aging, that they would work out in context with the state units on aging and the area agencies on how to provide an advocacy system through the aging network. What has to happen at the same time is a system through other state regulatory agencies which license private home health agencies. I do not know if this distinction is the same across the nation, but the area agencies are not subject to licensure in our state. So that there are regs for the private home health agency but there is not that tight a system for the services provided through the area agency. We prefer to see that system developed by the aging network itself.

Mr. **Grandy**. You have asked for an increased base funding level to $100,000. Is that correct?

Ms. **Duson**. Yes, but we are not proposing that the ombudsman programs would come up with those recommendations. I think that we would like to be a part of working out those recommendations, but we would look to the expertise of the Administration on Aging and the state units on aging.

Mr. **Grandy**. You would not ask the study to provide any kind of cost determination?

Ms. **Duson**. No new funds to the ombudsman program under the study.

Mr. **Grandy**. Okay. That is all I have to ask. I will yield back the balance of my time. Thank you.

Mr. **Kildee**. Thank you, Mr. Grandy. Mr. Visclosky?

Mr. **Visclosky**. Mr. Chairman, thank you.

I would like to get back to some of the line of questioning of my colleague from New York and return to the question of minority participation.

I have looked over some statistics that have been generated by the Congressional Research Service showing the number of participants in the supportive services. There was a significant decline from 1980 of about two million participants to 1985 where you have 1.5. 400,000 of those declines came in 1981. I do not want to assume that I know why that occurred. I would let anyone on the panel address that.

The second set, though, and really the basis of my question is on the nutrition services side. You had a spike in 1983. You had approximately 500,000 minority participants in the nutrition services in 1982, you had 590,000 in 1983, and then you were back down to 490,000. So, you went up in 1983 on the nutrition side 100,000 participants, you went down 100,000 in 1984. While on the supportive services side, it essentially remained flat as far as minority participation.

What happened in 1983 on the nutrition side with minority participation?

Ms. **Felcher**. That is a biggee. I guess I could sit here and try to dream something up for you, but I really have no way of assessing that with my knowledge, what happened. I do not want to come off sounding flippant, but it could have been a change in the method of tallying statistics. Often, when we get fluctuations like that that defy any reason that we can think of, we look at the reporting mechanisms. And I would look at that at this point in time. I would be really willing to go back and check with my colleagues about what they thought was the problem. I could not, right off the top of my head, give you an answer.

Mr. Visclosky. I would appreciate it, because if it is an aberration, that is one thing. If something was done at least in terms of trying to increase minority participation right in 1983, I would certainly appreciate knowing that.

Mr. Kildee. On that point, Mr. Visclosky, we will keep the record for the hearing open for two additional weeks. If you can come up with something on that, we would appreciate it. It will be made a part of the record.

Ms. Felcher. I certainly will do that.

Ms. Visclosky. The other point I would make on minority participation is—apparently there was a study in 1985 by Ms. McDowell's organization that indicated that there was variation on utilization by minority groups, depending on the services and the geographic areas involved. I am wondering, either Ms. McDowell or any one else on the panel, would you have a comment on that? Mr. Biaggi talked at some length and I think appropriately so on the outreach program. Is that one of the services that might be the variable here?

Ms. McDowell. I would like to say first of all, sir, that I am strongly convinced that minority participation is not declining in these programs. The other thing I would like to say is that I think there is a great deal more that we can do.

Based on the survey that we did and my conversations with my colleagues in state units, I think there are several issues to confront here. The first thing I would say is that Congress cannot be too strong or forceful in its language about the importance of targeting, particularly to minorities. Any additional emphasis that is given in the reauthorization would enable us to get a clearer message to the many providers under sub-contract in this progarm that this is an incredibly serious issue with all of us. So, we would appreciate any reinforcement for that policy.

The second point I would make is that in some ways, when area agencies and providers really get serious about serving minority persons and begin developing programs specifically targeted at minorities, the numbers of minorities served may not be all that impressive. In other words, we could have in the city of Milwaukee the entire minority population counted as being reached with public education and information and referral. I am much more impressed when I look at the budget of the Milwaukee Area Agency on Aging between 1981 and 1984 and find that in that time period they used all of their new available Title III-B funding to open four minority senior centers—one for hispanic elderly, one for—five, there were five—one for hispanics, one for American Indians, one for Asian Americans, and two for black elderly.

The actual numbers of persons served in those first few years in those centers is not overwhelmingly impressive compared to the numbers of minorities reached by public education, but the fact is those people were getting real service from bilingual bicultural staff at a very high cost per participant.

So, I think that the numbers of persons in the programs are not always the best indicator of the quality or appropriateness or effectiveness of service. I think it is very imcumbent on states to know exactly what is going on at the local level in terms of the appropriateness—cultural appropriateness of services and the seriousness with which this effort is undertaken.

But I hope that you do not rely only on those statistics to judge our performance.

Mr. **Visclosky**. Would anyone else care to comment or not?

Mr. **Proffitt**. I have a very limited perspective coming from Iowa in that we have a very small minority population. But from the local area agency on aging perspective, I would guess that the disparity in those years is essentially a different way of recording and reporting those figures. I am not sure how other states do this, but in Iowa for instance we are required to give estimated reports on minority participation, not actual. And so, when you are giving estimated, it very well may be that the lower number is indicating a more serious effort has been made, that it is reporting closer to the actual participation—because, as we have become more sophisticated and experienced in the field, you know, we have better information.

But I believe that, from my perspective, that is probably the primary reason for the difference. Certainly, we are not experiencing a decline in our own state. But, as I say, I do not know factually what is happening in other states.

One other point that I would like to make—as a result of being more sensitive to the needs of the minority population and trying, as a matter of fact, to identify what more can be done to better reach out and identify and encourage minorities to participate, in my own agency, for instance, we have discovered that we are serving more—and I am talking now actual, not estimated—more actual minorities in the home delivered meal portion of the program as over against congregate. And frankly, I do not—I am not sure why this is—we are just aware of this this last year and we are beginning to work on that.

Mr. **Visclosky**. If you had—I'm sorry.

Ms. **Felcher**. I can speak best for the city of Baltimore because I am from Baltimore and that is where I have been spending my professional career.

In the city of Baltimore, the minority population is about 60 percent. In the congregate meals program, we are at that same percentage—so that, I would have to agree with my colleage that I think we are, for the most part, doing the job and I really question the numbers and the recording mechanisms.

But in Baltimore, the other portion of it is that we are very sensitive to the needs of the elderly, and the majority of the staff of the nutrition program is minority. So that, there is an effort to understand and there is an understanding of the needs so that we approach the programatic aspect from the needs of the minority elderly.

Mr. **Visclosky**. Ms. McDowell indicated that we should make sure that we emphasize the importance the Congress attaches to this question. Do you pull up short of having any type of set aside against some percentages for the population to be served in a given area?

Ms. McDowell. I come up short on set asides on almost any grounds, whether it is this one or any other one. I think it is very difficult, from the perspective of Congress, to know what other funds are involved in these programs. And set asides may, in fact, add money to what is already a well funded service and may detract from funding we need in other programs.

In the state of Wisconsin, 45 percent of the money in the nutrition program is state money. So, we match the federal money almost dollar for dollar in the nutrition program, and we continue to—we do not use our transfer authority, we leave the money there. But what we do is use our state money in very selective targeted ways to solve problems that we have identified. And I think that, for example, we have a set aside for the 11 tribal reservations. We cannot do that easily through the Title III program because of—we have a direct state tribal relationship with our state funds. And the set aside for the native Americans uses a funding formula that is unique to the reservations, and we actually fund American indian elders at a rate of about $202 per capita, whereas we fund non-indian elders services at a rate of about $20 per capita.

There are—for us to have a specific set aside of the III-B on top of what we are already doing with our state money would not be useful. But frankly, I think that it is difficult from the federal level to anticipate the varieties of state funding patterns in order to make good judgment about how much one ought to set aside.

But I think clearer, more direct language about targeting and what that means and whether serving people in their proportion in the population is sufficient or whether real affirmative action in these programs would mean substantially greater proportion of resources going to these needy populations. I think that kind of guidance and language would be helpful. But I think a specific percentage would just become a problem for states that are managing other money in the same programs.

Mr. Visclosky. Thank you very much. I have no further questions, Mr. Chairman.

Mr. Kildee. Thank you very much. Do you have any further questions, Mr. Grandy?

Mr. Grandy. No, Mr. Chairman.

Mr. Kildee. I think you can see what the importance of and the interest of Congress in this program is by the number of members of the subcommittee who are here this morning. I think we may have set a record, particularly on a Monday morning. [Laughter.]

Mr. Kildee. I want to thank our witnesses for their testimony today. You have been very, very helpful. This has been a very good hearing. The record will remain open for two additional weeks for submission of additional material and we may be submitting some written questions to you for that purpose also. Again, we thank you, and the subcommittee will stand adjourned.

[Whereupon, at 1:15 p.m., the subcommittee adjourned, subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

THE UNIVERSITY OF MARYLAND
SCHOOL OF SOCIAL WORK AND COMMUNITY PLANNING

March 19, 1987

Honorable Dale E. Kildee, Chairman
Subcommittee on Human Resources
Committee on Education and Labor
U.S. House of Representatives
402 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Kildee:

I appreciate your keeping the record open and this further opportunity to comment upon the reauthorization of the Older Americans Act.

My comments on certain points raised during the March 10, hearing of the subcommittee are:

1. Introduction of a "Means-Test" in Title III of the Older Americans Act

Let me reiterate again my strong opposition to the use of any type of "means-test" for the determination of eligibility for services under the Title III program. By such a "test", I mean one where basic eligibility for services is based on an income and/or resources test. Such a provision would run contrary to the basic philosophy that has guided the development of the Older Americans Act since its enactment in 1965.

At the same time, I do not favor provisions that would give state and area agencies on aging the option of requiring cost-sharing under the supportive services/senior centers, congregate nutrition services, or home-delivered meals programs of Title III. Such a system could be a deterrant to receiving services. On the other hand, the Act could be changed to permit all Title III projects to solicit voluntary contributions for services rendered under Section 303 of the Act.

2. Reauthorization Period

A four year reauthorization period as you have proposed, would be a very constructive step. For one thing, the Older Americans Act programs have been operating successfully for some time now and enjoy broad support in the Congress. For another, a four year reauthorization would be good timing in view of the

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strong probability of a White House Conference in Aging being held in 1991.

3. Additional Authorization and Funds for In-Home Services

As indicated in my testimony on March 10, the Title III program should be strengthened with regards to the provision of in-home services. It would be my hope that this could be acomplished by an amendment to the Part B, Supportive Services and Senior Centers program of the Act. Also, it is hoped the language would clearly indicate that necessary in-home services would be provided to any older individual in need of such services.

4. Legal Services

In retrospect, I was not very responsive to the questions on legal services raised by Congressman Visclosky during the hearing. I do realize that some criticism does exist regarding the performance of state and area agencies on aging with regards to both the organization and the delivery of legal assistance activities. The House Committee on Aging has studied this subject in some depth, and their recommendations on the subject should be given careful consideration by the Subcommittee. One recommendation for instance, would make it clear that legal service demonstrations are to assist legal services providers, as well as state and area agencies on aging.

5. Minority Participation

The decline in minority participation, that has been reported in the various Title III programs in recent years, no doubt is a matter of serious Congressional concern. This is particularly so in view of the language included in the 1984 amendments to the Older Americans Act with regards to giving particular attention to the needs of low-income minority individuals.

As I indicated in my testimony, there are possibly multiple factors causing the decline. Some have suggested a switch in the national reporting system for Title III services may have resulted in a more accurate picture of minority participation than under th former Title III reporting system. Possible, but other factors could be inadequate state and area planning regarding the needs of the minority aging; ineffective outreach efforts to the minority population, failure to consult with and use minority organizations in either program planning or service provisions, access barriers in the physical location of services and programs in areas not readily accessible to older minority individuals; failure to overcome languare barriers in the delivery of services to certain groups of the minority older population who do not understand or speak English very well, and most important, inadequate minority personnel on the staff of State agencies, area agencies on aging, and direct service providers.

I am sure many proposals will be made with respect to this problem. One step that I would like to respectfully suggest is an annual report over the next four years by the Commissioner on Aging to the Congress on the progress being made by the "aging" network in increasing minority participation, including steps being taken at the Federal, State, and area level to increase minority participation in the Titles III, IV, and V programs of the Act.

6. Senior Centers

It was an oversight not to include more comments on the importance of senior centers in my testimony. For the record, I strongly support the reaffirmation of the "community focal point" language now included in section 306 (a) (3) of the Act regarding the designation of multipurpose senior centers as sites for comprehensive service delivery and coordination. Also, if the Subcommittee gives the "aging network" a broader role in community-based long-term care, it would be desireable to designate multipurpose senior centers as one of the primary sites for location of case management and basic in-home services. In addition, I would hope that the Administration on Aging could be strongly encouraged to support innovative projects, under the Title IV discretionary grant program, involving multipurpose senior centers.

I hope these comments will be of assistance to you and the other members of the Subcommittee.

Sincerely,

William D. Bechill

William D. Bechill
Associate Professor

WDB/tt

Statement Of The National Association Of Meal Programs

On: Extension of the Older Americans Act
To: House Education and Labor Committee
Subcommittee on Human Resources

Mr. Chairman, the National Association of Meal Programs is pleased to submit testimony on the reauthorization of the Older Americans Act which expires next year. I am Rochelle Berger, immediate Past President, and currently Chairman of the Legislative Committee of the National Association of Meal Programs, which is an association of professionals and volunteers, all working to provide nutritious meals to older Americans through both congregate and home-delivered meals programs. Our 547 members deliver about 140 million meals a year. Our members' programs are either privately funded or receive assistance from one or more government and private sources.

We believe strongly that the Older Americans Act should be extended. We also believe that one of the most important...in fact, a focal service...supported by the Act is the service of nutritious meals to older Americans, the disabled, frail, or those who are identified as high risk or vulnerable.

We believe that the trend towards allowing more and more funds under the Act to be transferred between service categories operates to the detriment of the nutrition component of the Act's programs. The funding for the nutrition component has remained relatively static over the last few years based on a per meal assistance. This situation has created waiting lists for many home-delivered meal programs in particular, and has placed all our members' programs in a situation where it is very difficult to serve the target population and provide that service to increasing members of eligible persons who request and need it.

We are concerned that the role that the meals component of the program plays in acting as a catalyst for other services is not appreciated or recognized as the reason for entry into network offered services for many older adults. We who provide the meals are the first and most consistent contact which the target population has with the services and programs of the Act. If we cannot meet the designated target population's needs for meals, the reality is that other services available under the Act may never reach those who need them.

There are those who have said that the meals component of the Act's programs have not expanded but still serve the same people first serviced 10 years ago, except that those people are older. This just could not be further from the truth. At a recent Board meeting of our association, a survey of the 18 members present indicated that an overwhelming majority were adding eligible recipients as space and funding allowed. Program providers take their responsibility to provide service very seriously, and we see the increased transfer authority as detracting from a program's ability to provide service since good nutrition just has not been given priority by either the Administration on Aging, or in some cases, state and area offices on aging. Moving more towards increased transfers is the first step, in our view, towards a block grant. The National Association of Meal Programs believes strongly that the loosers under such a consolidated program would be those in the target population who need a daily meal to stay healthy and out of the health care system which is so costly. A good example of this approach to cutting back overall monies under the block grant can be seen in the Administration's budget requests this year. No specific program is cut, but the funds for a program block are. We see the block grant approach as squeezing the Older Americans Act programs little by little until their effectiveness and ability to respond to the needs of the target population is impaired irreparably.

We believe that the efforts which have been made towards hospital stay cost containment through the DRG's have increased our various caseloads, and there has been little recognition that the increased demand for meals particularly for the homebound, does not help make the meals appear. Services and food require money and volunteers to make things happen. The members of the National Association of Meal Programs all provide home-delivered meals and 40% of the membership provide congregate meals as well. We average five volunteers for every meal served. It can be said that volunteers in general, provide a myriad of inkind supports and make community based programs cost effective.

We encourage the Congress to recognize the importance of nutrition programs in your action on the reauthorization, and also to recognize that the separate entitlement between funding for home-delivered and congregate meals must be retained. The separate entitlements cannot and should not be blended. Congregate meals needs a base of support and the home-delivered meal component needs its financial base as well. The change that should be indicated in this level is an allowance for inflation and an increase in the base funding level because of documented need for services.

Further, the National Association of Meal Programs opposes efforts to reduce levels of funding for other Older Americans Act Programs which additionally contribute towards paying for the meal component and other nutritional services.

With reference to Section 3(d) which refers to In-Home Services to Frail Older Individuals, the National Association of Meal Programs is supportive of this new initiative and encourages the enactment of a broad appropriation. As people age chronologically, the need for additional services is tantamount to avoiding costly premature institutionalization. In-home services as defined in Section 344 finally recognizes the need for expanded services already defined by service providers across the country, as requested by recipients of meal programs.

Mr. Chairman, older Americans of our nation, the disabled, the frail, the vulnerable, need the nutrition services provided by meals programs. Our programs provide the outreach which binds together the continuum of services for these groups. We are opposed to a means test for these nutrition services, however, we support efforts to target our services to those who need it most. To require cost sharing for services provided through the Older Americans Act would precipitate a means test which, to reiterate, the National Association of Meal Programs opposes. We urge the Congress to recognize these concerns in your actions on the reauthorization of the Act.

PREPARED STATEMENT OF JONATHAN B. HOWES, PRESIDENT, NATIONAL ASSOCIATION OF REGIONAL COUNCILS

Mr. Chairman, I am Jonathan B. Howes, President of the National Association of Regional Councils (NARC). In addition to my duties as President of NARC, I am a Councilman from the Town of Chapel Hill, North Carolina and a member of the Triangle J Council of Governments, located in Research Triangle Park, North Carolina.

NARC appreciates the opportunity to submit the following testimony on reauthorization of the Older Americans Act of 1965. We feel strongly that the subject of these hearings, "The Older Americans Act Reauthorization: State and Local Perspectives" is an important one. The existing aging network of area agencies and state units on aging is well suited to continue to offer community based services to the nation's growing elderly population. Moreover, we feel that regional councils (working as AAA's) should continue as a vital element in the aging network. In short Mr. Chairman, we appreciate your leadership in recognizing the distinctive roles that state and local governments play elderly service delivery.

Regional Councils as Area Agencies on Aging

With the passage of the Older Americans Act in 1965, many states and/or localities decided to place the AAA function in regional councils. 187 of the 600 area agencies on aging operate under the umbrella of regional councils and these include a broad cross-section of both rural and metropolitan regions. In several states, regional councils, while not serving as AAAs, were utilized to establish the mechanism for the AAA's function.

Regional councils have been effective in responding to service mandates under the Older Americans Act within the limits of the resources provided to do the job. Their approach to services, in terms of emphasis and packaging, has differed depending on local conditions, needs and desires. The direction in recent years has been toward provision of a wide spectrum of services. Greater efforts are being made to identify the most vulnerable (frail and minority) individuals within the elderly population and provide outreach services. The degree of state policy and administrative support has been a key factor in determining the effectiveness of respective regional council aging programs.

Regional councils operating aging programs have traditionally enjoyed a high degree of support among local elected officials and the elderly. Part of the reason for this broad-based support is the unique ability of regional councils to bring into the aging program planning and development process many municipal officials not ordinarily involved in human service programs. The human services field has traditionally been the province of state and county welfare agencies. The involvement of local elected officials and broad-based advisory committees established by the councils has payed handsome dividends in terms of additional matching funds and valuable in-kind services.

The regional planning process and areawide clearinghouse function under E.O. 12372 enables local elected officials to coordinate their actions in a wide range of program areas that impact the elderly. For example, regional councils that are designated regional planning agencies under federal transportation legislation are able to integrate the special transportation needs of the elderly into their model transportation plans for their area. Councils have also been instrumental in efforts to incorporate aging programs concerns into manpower planning activities under the Job Training Partnership Act.

The advantages of housing an area agency within a regional council are numerous. Area Agency staff can draw on the expertise of other professionals and resources not ordinarily found in most single-purpose agencies (e.g. legal contracts, regional data collection and processing, engineering, and program and fiscal management). Many regional councils are repositories for census and other data with expanded capacity to analyze and aggregate it. Councils also have vast experience in competitive bidding (through joint purchasing programs for local governments) and performance contracting.

Across the country, local elected officials are very supportive of the role for regional councils in programs under the umbrella of the Older Americans Act. The strong linkage that exists between local elected officials and local governments they represent on regional council boards builds a public accountability factor that is not typically found in most single-purpose or nonprofit institutions.

Recommendations for Changes in the Older Americans Act of 1965

In February, the NARC Board of Directors met in conjunction with our annual Washington Policy Conference. At that meeting the Board unanimously approved a set of policies on reauthorization of the Older Americans Act. A summary of those policies follows.

NARC urges that Congress reauthorize the Older Americans Act of 1965 in order to continue the current system of home and community based care for our nation's growing elderly population. The changes that we recommend in this document are intended to be only to be minor changes in the law. As an association, we believe that the existing structure has been effective in serving the needs of older Americans.

The Aging Network

NARC believes strongly that the existing network on aging of Area Agencies and State Units on Aging is a proven framework for serving the nation's elderly as it covers the entire country. Attempts to improve the family and community based system of services for older Americans should be done within the context of this network.

Regional Councils as Area Agencies (AAA)

NARC reaffirms its position that regional councils be given preference in administering aging programs with the concurrence of local government. Accordingly, NARC strongly opposes any policy "favoring" the designation of single-purpose organizations and/or other nonprofit organizations.

Scope and Focus of Functions

Congress should authorize and fund programs under the Older Americans Act that provide support for alternatives to institutionalization for the elderly. Moreover, the Act should continue to support the Area Agency as the primary planning and service delivery mechanism for the vulnerable elderly under the Older Americans Act. In addition, should be given to encouraging Social Service Block Grants, Medicaid, Medicare as well as state and local revenues to be integrated into the program through case management and other related activities.

NARC endorses a reauthorization of the Older Americans Act of 1965 which includes and adds provisions for additional administrative flexibility, increased program authorizations, continued emphasis on services to functionally impaired, minority and low-income elderly and authority to initiate efforts to coordinate community-based long-term care services.

Status of AOA within HHS

NARC urges an upgrading of the Administration on Aging within the Department of Health and Human Services. An Assistant Secretary for Aging should be established to represent the interests of all older Americans within the Department of Health and Human Services.

Targeting

NARC supports language within the Act which gives preference for services to older individuals with the greatest economic and social needs, with particular attention given to low income and minority individuals.

During its 1987 reauthorization of the Older Americans Act, NARC recommends that Congress consider the following changes:

- Flexibility -- Area Agencies should be given greater flexibility and discretion to enable them to develop more comprehensive and coordinated service delivery systems, and more effectively target the most vulnerable elderly in their communities.

- Priority Services -- Congress should grant maximum discretion to Area Agencies to determine priority services in their geographic areas based on Area Agency and intrastate differences.

- Increased Demands on Home Based Care -- The Older Americans Act should not supplement Medicare through Home Care and support services without additional new funds consistent with new demands on the system. NARC recommends that Congress consider transferring a minimum of 1 percent of the savings from Medicare cost containment measures (such as DRG's) to home and supportive services administered under the Act.

- Case Management -- Client centered case management systems should be used as the optimal means to avoid costly and unnecessary institutionalization. Functional assessments should be used to determine the needs for services within the community.

- Resource and Program Development -- Make both resource and program development a key function of Area Agencies and an allowable cost for those seeking additional support for needed services.

- Ombudsman and Quality Assurance -- With the growing elderly population living longer and with the Medicare system returning them home sooner, more elderly are receiving home-based care from the aging network fostered under the Act. However, the federal government has reduced its regulatory responsibility for in-home care and institutional care when the system needs greater accountability. NARC, therefore, urges that the long term care ombudsman program become a separate subsection of Title III with a separate authorization of appropriations providing additional funds. Moreover, Ombudsmen should be granted limited immunity from civil suits and protected from the impact of OMB A-122.

- Liability -- In response to the liability crisis facing all levels of local government, NARC endorses the inclusion of statutory language limiting the liability of Area Agencies on Aging.

- Title V -- The Title V (The Senior Citizens Employment Program) of the Older Americans Act should be administered by the same network as are other programs authorized by the Act.

- Administration -- Increase the area agency administration share from 8.5 percent to 11 percent to implement coordination mandates.

- Voluntary Contributions -- Allow local development of a sliding scale for recommended voluntary contributions.

Long-Term Care for the Elderly

Regional councils, as area agencies on aging, should play a lead role in developing a continuum of community based long-term care services that will enable the elderly to live independent lives within their home communities. NARC supports changes in the Older Americans Act and other legislation relating to the elderly that would place more emphasis on the development of long-term care services which incorporate the following principles:

- Emphasis on local needs and involvement of local elected officials in the planning and management of aging programs. The regional council structure offers significant advantages for the development of long-term care systems. These include strong ties to local elected officials, accountability, planning and assessment skills, and low administrative costs.

- The extent of local case management should be negotiated and determined at the local level and not mandated by federal legislation. Case management can be an important tool in making the most effective use of available resources and is a legitimate activity for regional councils. However, the impact of case management is presently limited by the scarcity of alternatives to institutionalization in most regions.

- Stronger planning and coordination authority should be given to regional councils as area agencies on aging to develop community based long-term care systems. Progress in developing support systems for community based independent living arrangements will depend a great deal on the response of service providers and policy authorities outside the area agency on aging network.

- An intergovernmental partnership is required to develop effective community based long-term care systems. The federal government must continue its financial support, at least at current levels. States must pass legislation establishing community care systems, recognizing and supporting the role of regional councils in the development and implementation of such systems.

- Additional resources will be needed to implement a long-term care system if cuts are to be avoided in current aging programs.

  Congress should authorize use of Title 19 Social Security Act funds for home and community-based care. In the interim, waivers should continue indefinitely unless revoked for cause (i.e., noncompliance/ nonperformance). Any revocation process should include an appeals and public hearing process.

Title IV

NARC supports channeling Title IV Discretionary Training, Research and Demonstration funds to Area Agencies to strengthen the aging network's ability to serve the needs of the elderly, and respond to community needs and priorities.

To the maximum extent feasible, local governments should be given flexibility in the design and implementation of programs under the Older Americans Act with regulations governing these programs based upon performance standards rather than federally mandated levels of program activity.

Single Administrative Unit at the State Level

NARC urges Congress to support regulations governing the Older Americans Act which continue support for a single administrative unit at the state level with responsibility for aging programs. This unit should, as is currently the case, seek input from area agencies in developing a state plan. Regulations should also continue to require a uniform funding formula for area agencies on aging. Provisions describing the type of agencies that may be designated as area agencies on aging should not be removed in any revision of the regulations, nor should these regulations eliminate staffing requirements at the area level. Finally, where the state must designate an area agency, regulations should prescribe a reasonable period of time in which this designation should be made.

First Right of Refusal

NARC urges that the present system of Area Agencies on Aging designated by AOA be maintained unless demographic and population shifts justify a review of existing boundaries. In such cases, a local governmental unit's first right of refusal shall apply only if the following criteria apply:

- A local government can demonstrate that it continues to fund services commensurate to meet the needs of the elderly poor residing within that local government's jurisdiction, based on the most recent census data figures.

- A local government's boundaries are reasonably contiguous to those of the area agency on aging (single jurisdiction) under existing state designated boundaries.

- A state shows that it has carried out provisions included in the federal regulations governing the designation of planning and service areas, designation of area agencies, withdrawal of area agency designation and continuity of services.

In multijurisdictional areas where a local government is not eligible for first right of refusal, where there is a need to improve accountability to local elected officials, regional councils which represent all local governments should be given preference in administering aging programs unless state law provides otherwise.

Mr. Chairman, members of the Committee, NARC appreciates the opportunity to participate in these hearings leading up to eventual reauthorization of the Older Americans Act. We endorse your commitment to improving the system of community based care for our growing elderly population. If there is any assistance we can offer, please do not hesitate to call on us.

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COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
320 CANNON HOUSE OFFICE BUILDING
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SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1987

Ms. Jill Duson
State Long Term Care Ombudsman Program
c/o Maine Committee on Aging
State House Station #127
Augusta, ME 04333

Dear Ms. Duson:

Thank you for your testimony before the Subcommittee on March 9, 1987. Time did not permit us to ask you as many questions as we would have liked at the hearing. In order to help us complete our hearing record, would you please be so kind as to answer the following questions in writing. A response by March 30, 1987 would give us the maximum time to consider your views on these additional matters.

Questions

1) Under existing law, ombudsmen are required to exercise oversight on a number of types of facilities. What have you been able to accomplish in the area of board and care homes?

2) Could you provide us with some additional information concerning the need to give formal recognition to local ombudsman programs in the Act? What would be the effect of such an action?

3) You note in your statement that the Institute of Medicine Study recommended that ombudsman programs be funded at a minimum level of $100,000. Do you know how this amount was calculated?

4) Whenever Congress creates a new authorization, the question arises as to whether the Appropriations Committee will actually fund it. If the proposal for a line-item authorization for the ombudsman program is adopted, should some sort of fall-back language be included as a protection should the appropriations not be adequate?

Your cooperation in this matter is greatly appreciated. I look forward to working with you as the reauthorization of the Older Americans Act progresses.

Sincerely,

Dale D. Kildee
Chairman

National
Association
State Long Term Care
Ombudsman
Programs

C/O Maine Committee on Aging, State House
Station #127, Augusta, Maine 04333
(207) 289-3658

March 26, 1987

Dale E. Kildee, Chairman
House Committee on Education and Labor
Subcommittee on Human Resources
320 Cannon HOB
Washington, DC 20515

Dear Representative Kildee:

Thank you for the opportunity to testify before the subcommittee on March 9, 1987, and for your interest in the State Long Term Care Ombudsman Programs (SLTCOP). Following are my responses to the questions contained in your letter dated March 16, 1987.

1. **Ombudsman Services in Board and Care.**

The 1981 OAA amendments expanded the required scope of the Ombudsman Program beyond nursing home by defining long term care facility to include boarding care and group home settings. This expansion to board and care settings was approved with no accompanying increase in funds. The SLTCOP have therefore been required to reallocate limited program resources in order to respond to board and care consumers. According to the most recent national data available, complaints against board and care facilities represented 12% of all complaints received by SLTCOP. (National summary of SLTCOP reports for FY 1984, released by AoA in March, 1986) During that same time period overall complaints to the Ombudsman programs increased by 75% from 40,727 in FY 1982 to 71,128 in FY 1984.

Based on a random poll of selected programs conducted to prepare our response to this question, board and care complaint handling has increased moderately through 1985 and 1986. Board and care concerns now represent 15% of the complaints handled.

Ombudsman need increased resources in order to advocate effectively for our original constituency: nursing home residents. Clearly however, the residents of board and care homes are as vulnerable as those who reside in nursing homes. Program funds are inadequate to enable the Ombudsman to accomplish the program goals currently outlined in the OAA.

2. **Formal designation of local programs by the office of the SLTCOPs.**

The primary focus of the Ombudsman program is to assist individual residents and their families to negotiate with facilities and regulatory agencies. Most Ombudsman programs rely heavily upon volunteers to carry out individual problem solving. The OAA however requires state assurances that "the ombudsman" has appropriate access to facilities and patients' records. In many states this is interpreted to mean that only the individual designated as state ombudsman has this authority. Yet it is the local ombudsman who is most likely to visit residents and assist in resolution of individual problems.

The vague statutory language has been in large part responsible for problems of access to nursing homes experienced by local area ombudsman programs. Lack of clarity on this issue has adversely impacted the ability of some programs, State and local, to respond effectively or provide outreach to long term care residents.

The National Association of State Long Term Care Ombudsman Programs (NASOP) suggests restructuring the OAA description of ombudsman functions by assigning program responsibilities to an "Office of the State Long Term Care Ombudsman." In this scenario, quality assurance measures such as technical assistance and training, as well as standard complaint investigation policies and procedures would be provided to all programs or individuals designated to represent the office. In addition, necessary investigative powers including clear access to facilities, residents, and resident records as well as protections such as immunity and legal support , may be extended through the office to all of its designees.

3. **Institute of Medicine (IOM) recommendation for Ombudsprogram base funding.**

It is unclear how the IOM Study Committee reached the specific figure of $100,000 as the recommended minumum annual budget for state Ombudsman programs. The IOM Committee did however specify that this amount was intended to support "at a minimum a full-time professional and secretary and sufficient travel and training funds to recruit, train and certify volunteers as local area Ombudsmen." It is the position of the NASOP that this amount may be minimally adequate to support the basic program activities.

The IOM Committee also recommended appropriation of additional funds based on a formula related to the elderly population of the state. One addition program element to be factored into the base funding recommendation is our volunteer and community involvement mandate. A minimally staffed SLTCOP should include a full time Ombudsman, Secretary, and Volunteer/Training Coordinator. In absence of a means to quantify these program needs the association has recommended that the reauthorization committee look to the IOM report. It is my personal view however that the recommended amount is inadequate and that base funding should be in the range of $150,000.

4. **Protective language in the event of inadequate appropriation.**

Despite the breadth of the statutory authority and responsibilities accorded to the Ombudsman program, Congress implicitly accorded the program low priority within the OAA in that (1) it is authorized in Title III where it is juxtaposed with the service programs for the non-institutionalized elderly, i.e. with AOA's major program responsibilities, and (2) each state program is authorized to use not more that noe percent of its AOA Title III federal funding or $20,000 whichever is larger. Current OAA base funding requirements of 1% of III-B funds are insufficient to support current program clientele who make up over 5% of the elderly population. Ombudsman have looked forward to the 1987 reauthorization process as a opportunity to reaccess the status of our programs within the Act and to seek an improved funding base.

Many members of the Congress have expressed strong support for this program and a desire to assist the constituency which we serve. We hope that the subcommittee on Human Resources will be moved to recommend a new authorization and substantive improvement for the SLTCOP. We implore the subcommittee however, to incorporate specific maintenence of effort language to protect the current program funding sources and ensure that (1) any new funds are not used to displace existing budget commitments, and (2) the SLTCOP will be protected in the event of failure to obtain funding under a new appropriation.

Thank you again for the opportunity to present these comments.

Sincerely,

Jill C. Duson, President

**National
Association
State Long Term Care
Ombudsman
Programs**

**C/O Maine Committee on Aging, State House
Station #127, Augusta, Maine 04333
(207) 289-3658**

FACT SHEET

STATE LONG TERM CARE OMBUDSMAN
PROGRAM

Background

The State Long Term Care Ombudsman Program (SLTCOP) was initiated in June 1972 with the granting of seven demonstration projects to improve the quality of care in nursing homes. This was the response of the Nixon Administration to the reports of unacceptable conditions in America's nursing homes.

Based on the success of the demonstration projects, the 1975 Amendments to the Older Americans Act (OAA) gave the Commissioner on Aging authority to make grants to states to develop ombudsman programs. In the 1978 Amendments to the OAA, Congress required every state agency on aging to establish and operate, either directly or by contract, an ombudsman program. The 1981 Amendments to the OAA expanded the required scope of the Ombudsman Program beyond nursing homes by defining long-term care facility as "any category of institutions, foster homes or group living arrangements in which a significant number of recipients of Supplemental Security Income (SSI) benefits is residing or likely to reside."

Major Program Responsibilities

- Investigate and resolve complaints regarding the health, safety, welfare and rights of residents, made by or on behalf of residents, of long term care facilities;
- Monitor the development and implementation of federal, state, and local laws, regulations, and policies with respect to long term care facilities;
- Provide information to public agencies regarding the problems of older people in long term care facilities;
- Train volunteers and promote the development of citizen organizations to participate in the ombudsman program; and
- Establish a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long term care facilities for the purpose of identifying and resolving significant problems, with provision for submission to the agency responsible for licensing or certifying long term care facilities in the state and to the Commissioner of the Administration on Aging on a regular basis.

Funding

- The State Long Term Care Ombudsman Program under the OAA provisions is to be funded at a level of "no less than one percent of Title III, Part B, social services monies or $20,000 whichever is greater (with exceptions).
- Five percent of older Americans in the United States reside in nursing homes.
- The Ombudsman Advocacy System activities are the only direct services provided to residents of long term care facilities under the Older Americans Act.
- A total of 639.5 million dollars is spent on Older Americans Act direct service programs (specifically Title III monies which include social service programs and nutrition programs).
- Nationwide Ombudsman Programs received 9.4 million dollars in Older Americans Act Funds or .01 percent of the Older Americans Act direct service program dollars.
- The five percent of older Americans residing in long term care facilities receive less than one percent of Older Americans Act Funding for their direct service programming needs.
- The amount and percentage of funding to long term care residents under the Older Americans Act is not representative of their proportion in the population.
- Low and/or inadequate funding of the State Long Term Care Ombudsman Program is clearly a concern for the majority of ombudsman programs nationwide.

Table 1

ILLUSTRATION OF TOTAL OLDER AMERICANS ACT
(OAA) FUNDS AND PERCENT OF OAA FUNDS
RECEIVED BY OMBUDSMAN PROGRAMS

FY	OAA Funds (Total Title III Funds)	OAA Funds Received By Ombudsman Program	Percent of OAA Funds Received by Ombudsman Program
'84	639.5 million	9.4 million	.01%

NOTE: The funding and complaint figures provided throughout this fact sheet reflect 1984 data. 1984 is the last year for which the Administration on Aging has compiled data regarding Ombudsman activities.

Complaint Statistics

- Ombudsmen received over 71,000 complaints in FY '84. In FY '82, ombudsmen received 40,727 complaints (an increase of 75 percent is reflected in the FY '84 complaints over FY '82 complaints).

- Seventy-two percent of these complaints were regarding nursing homes, and twelve percent were regarding Board and Care Facilities.

- Seventy percent of the complaints were verified or substantiated.

- Seventy-five percent of all complaints received were investigated by the ombudsmen.

Future

- The Ombudsman Program has long been recognized by many members of Congress as an important factor in guaranteeing that residents of long term care facilities receive quality care.

- The Institute of Medicine (IOM) Report, "Improving the Quality of Care in Nursing Homes" has recommended that the ombudsman program be strengthened and recommended the Older Americans Act be amended. Some of these recommendations are as follows:

  - establish the ombudsman program under a separate title in the act;
  - increase funds for state programs by authorizing federal-state match formula grants for state ombudsman programs. Guaranteeing an annual range of $100,000, plus an additional amount based on the number of elderly in the state;
  - exempt the ombudsman programs, including substate ombudsmen, from antilobbying provisions of OMB Circular A-122; and
  - the secretary of HHS should direct the Administration on Aging (AOA) to take steps to provide effective leadership for the Ombudsman Program ... Priority should be given to establishing a national resource center for the program that would develop in consultation with state programs, an information clearinghouse, training and other materials to assist states and guidance to states on data collection and analysis.

- Ombudsmen agree with the recommendations in the IOM report, and the facts indicate that the majority of the Ombudsman Programs are inadequately funded.

- Ombudsmen hope the future will lead to Congress implementing the recommendations of the IOM report in order to continue the effectiveness of the State Long Term Care Ombudsman Program.

Compiled by
Shirley A. Ellis
Wisconsin SLTCO
October, 1986

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SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1987

Ms. Donna McDowell
c/o National Association of State Units on Aging
600 Maryland Ave., S.W., Suite 208
Washington, D.C. 20024

Dear Ms. McDowell:

Thank you for your testimony before the Subcommittee on March 9, 1987. Time did not permit us to ask you as many questions as we would have liked at the hearing. In order to help us complete our hearing record, would you please be so kind as to answer the following questions in writing. A response by March 30, 1987 would give us the maximum time to consider your views on these additional matters.

Questions

1) The subcommittee has been requested to consider an amendment that would permit area agencies on aging to provide case management as an access service without seeking a waiver from the state as required under existing law. What is your view of this proposal?

2) If area agencies were to become more active in the provision of case management services to the population in need of community-based long term care, would this have an effect on other area agency responsibilities?

3) What effect would mandatory contributions have on program participation for supportive services?

   Is there any evidence is there to show that mandatory contributions will not decrease participation by those who are most in need of services?

4) If this proposal were adopted, at what point would an older person be required to contribute toward the cost of a service?

   Would this be determined by each state? If so, would it be possible to have people with identical incomes in different states paying different amounts for the same service?

5) To what services are you proposing that mandatory cost-sharing be applied?

Ms. Donna McDowell
March 16, 1987
Page 2

6) Are there any estimates on how much income states could raise by setting mandatory cost-sharing schedules?

7) Your association has requested that the advocacy language, that used to be in the federal regulations, be included in the Older Americans Act. Can you describe the importance of advocacy and why this statutory language is needed?

8) The Committee has been asked to consider amendments that establish a 6 percent set aside for each Title III-B priority service. What effect would this proposal have?

9) The Committee is being told that priority services are not being funded by each area agency. What alternatives exist for ensuring that the priority services are carried out?

Your cooperation in this matter is greatly appreciated. I look forward to working with you as the reauthorization of the Older Americans Act progresses.

Sincerely,

Dale E. Kildee
Chairman

mk

Questions from Sub-Committee on Human Resources

Question

1. The subcommittee has been requested to consider an amendment that would permit area agencies on aging to provide case management as an access service without seeking a waiver from the state as required under existing law. What is your view of this proposal?

Reply

1. We oppose this proposal. Case Management is a critical component of a community based long term care delivery system. The aging network - State Units on Aging, Area Agencies on Aging and service providers - have a responsibility to support the development of comprehensive and coordinated care systems.

States have been designing community-based long term care case management systems since the 1970's, many of them involving Area Agencies on Aging staff as case managers. Other case management systems have been established through county governments, private non-profit agencies or social services contractors of Area Agencies on Aging.

Since the one of the goals of a community care system is to facilitate an individual's access to needed services, it is important that uniform statewide systems of assessment, case planning and case management be clearly delineated. The current fragmentation of services supported by multiple funding sources would be exacerbated by the creation of duplicative, parallel case management systems. State government, through the state agencies administering Medicaid, Social Services Block Grant, Older Americans Act and state-only programs are responsible for achieving consensus on the purposes, organizational focus, standards and financing of service delivery systems supported with multiple resources. Where it has been viewed as the most effective design, states have granted the necessary waivers to enable area agencies to perform case management. In states where other agencies have been given responsibility for case management, area agencies on aging have other important functions in support of a coordinated community care system. However, in those instances it would be both confusing to older people and an inefficient use of public funds to allow the establishment of duplicative case management systems.

Question

2. If area agencies were to become more active in the provision of case management services to the population in need of community-based long term care, would this have an effect on other area agency responsibilities?

Rely

2. In those states with a long history of case management, such as Pennsylvania, there has also historically been another major source of funding besides Title III available to enable the area agency to perform its planning, advocacy and community development functions. Even in those cases, the resources devoted to case management generally far exceed other functions. In addition, targeting of all services tends to focus more extensively on the most severly functionally impaired as the primary indicator of need. However, there are distinct benefits to be gained from

involving area agencies in case management, such as the focus on the frail, increased coordination with long term care providers and the Medicaid providers of home health, etc.

Some states have determined that the area agencies have the best capacity to perform this case management function. Other states have identified through their state planning processes that it would be more appropriate to achieve the beneficial effects of case management through another system. Priorities for area agencies have then focused on other advocacy efforts like helping older persons deal with the Medicare claims systems, improving hospital discharge planning, coordinating transportation resources in rural or urban areas, establishing new community initiatives for victims of Alzheimer's, etc. If an area agency relies mostly on Title III, it is unlikely that it would be possible to finance case management staff and at the same time support these other types of advocacy and program/community development efforts.

Question

3. What effect would mandatory contributions have on program participation for supportive services?

Rely

3. Program participation would depend, as it does now in a voluntary contribution environment, on both state policies and local program management. Most fears in the aging network about introducing mandatory cost-sharing are fears of the federal government moving in and establishing exclusionary policies. State and area agencies have a 15 year history of

outreach, public information and program enhancement to encourage participation by an elderly population that is reluctant to seek help. We do not want to change that philosophy. We do think that a majority of older persons would accept the notion that for certain high cost services, persons with higher incomes should be required to participate in the cost. Some older persons may choose not to accept supportive services with a co-payment, just as some older persons choose to drop other programs if they don't approve of a program or policy change. A few older persons are likely to give up a service if they don't like a new provider (who came in through a competitive bidding process), or if the schedule or content of a program or meal changes. The aging network is accustomed to older persons exercising their personal preferences in making program choices. The network does not have a history of seeking to exclude persons for financial reasons. The aging network also has a record of including older consumers in decisions about policy and program design, and older persons should expect to be involved in decisions about cost-sharing.

Program participation will show a net increase in services with cost-sharing because more funds will be brought into the program, unless that program already has a high rate of voluntary contributions. Persons in greatest financial need would not have to participate in cost sharing. Those most in need based on functional disability criteria will be offered cost sharing which is a substantially lower-cost option than residential or nursing facilities, and which does not require spenddown for eligibility like Medicaid home health, or a rigid medical standard of need like Medicare. Title III will still be the best option for most older persons with severe disabling conditions. Older persons who are in great economic need are already participating in programs with income tests and co-payments, such as Medicaid, the Low Income Energy Assistance Program, Social Services Block Grant etc., and are not deterred by means-testing. If State Units on Aging, as administrators of the Older Americans Act, believed that mandatory contributions would always deter those most in need of services, we would not be so irresponsible as to propose the authority to implement cost-sharing. Such a concept as cost-sharing would be entered into cautiously by states which have established goals for targeting, in order to assure service to those in greatest need.

Question

4. If this proposal were adopted, at what point would an older person be required to contribute toward the cost of a service?

Would this be determined by each state? If so, would it be possible to have people with identical incomes in different state paying different amounts for the same service?

Reply

4. Standards for cost-sharing could well include an income floor of 150% of poverty, below which no mandatory cost-sharing could be applied. Standards could also assure that no one be denied services for refusal to cost share if their health, safety or personal dignity was at risk. Finally, persons could not be denied services entirely but be allowed to receive services for a reasonable period of time until the individual could make other arrangements for assistance, thereby allowing the consumer time to evaluate the service before making a decision on cost-sharing. That might translate into language

that says cost sharing cannot be applied until after the first month of service in order to enable the consumer to make an informed choice about whether to participate in a program which has cost-sharing features.

It is essential that the policies for cost-sharing be established by each state. It is only at this level that older persons can participate in the decision-making; there is real concern about federal standards for "means-testing" which do not take into account local standards and notions of fairness.

There would of course be state-by-state differences in which services have cost-sharing and at what level, just as there are state-by-state differences in the Social Services Block Grant, Medicaid, Low Income Energy Assistance, state supplements to SSI, and every other federal program. It is precisely because other federal programs operate to so differently across state lines that it is so important to make Title III fit better with other service systems for older persons. Today, within the same state, older persons may pay different amounts for the same service, depending on which funding source pays for the service. In one county, a service may be "free" under Title III, and in an adjacent county, the service may only be funded by SSBG which has either a cost-sharing arrangement or a straight means test which excludes higher income participation.

Question

5. To what services are you proposing that mandatory cost-sharing be applied?

Reply

5. We propose that states decide, in consultation with older persons. Primarily, states will choose to implement cost-sharing in those programs which older persons would find acceptable, and where cost-sharing would not deter participation due to excessive administrative processes. Congregate programs which service people on a "drop-in and participate" basis will continue to function with voluntary contribution systems because the high and variable participation makes a formal intake process too cumbersome. Programs for the very frail which involve some case planning and higher cost services, such as adult day care or specialized transportation, already have intake and assessment procedures; such programs could be substantially expanded if higher income participants share in the cost of services. In-home services and home-delivered meals also involve needs assessment and case plan functions which already collect income information in order to enable providers to determine health insurance and/or Medicaid eligibility for home health, eligibility for SSI supplementation, etc. It is sometimes difficult to determine how to use Title III in a service plan using multiple funding sources which require cost-sharing; the uniqueness of Title III contributes to the fragmentation of in-home services.

Question

6. Are there any estimates on how much income states could raise by setting mandatory cost-sharing schedules?

Reply

6. It is not possible to do a reasonable estimate because it depends on the services to which cost-sharing is applied. In our state funded Community Options Program, about 75 percent of the elderly who have an assessment and case plan receive services under a cost sharing plan; 25 percent have no obligation. Fifty percent pay part of the cost of care; this group would not be eligible for Medicaid in a nursing home, but would spend down to Medicaid within 6 months. Cost sharing in COP is more desirable than spenddown. Another 25 percent pay the full cost of care (100 percent share of cost).

Our primary interest in cost sharing is not the potential revenues generated but rather the beneficial affects on targeting public resources to the most economically disadvantaged, enhancing equitable treatment of individuals across federal and state programs and coordinating services as part of an individual care plan.

Question

7. Your association has requested that the advocacy language, that used to be in the federal regulations, be included in the Older Americans Act. Can you describe the importance of advocacy and why this statutory language is needed?

Reply

7. There are an extraordinary number of public and private services and benefits for older persons, particularly in the health and insurance arenas. Older persons can face major life decisions in the choice of a benefit or

program, in the denial of a benefit or program, or in the change of a program policy or benefit.

The Older Americans Act network is unique among the public and private systems of services and benefits. It has a public responsibility to represent the interests of older persons and to empower older persons to participate in an informed way as their own representatives in the planning and decision-making processes.

The role of the aging network is perceived by some private and public administrators exclusively or primarily as a service-delivery system like any other. This perception may result in the curtailment of the network's advocacy, mediation and community development/catalyst roles. The inhibition of the advocacy function can occur by regulatory restraint (as OMB A-122) or by organizational design and placement, or by overbalancing the agency with direct service functions which limit the availability of resources for advocacy. It is therefore important to have a clear Congressional message regarding the unique advocacy role of the aging network.

Question

8. The Committee has been asked to consider amendments that establish a 6 percent set aside for each Title III-B priority service. What effect would this proposal have?

Reply

8. Federal earmarking of OAA funds cannot take into account funding patterns within states. For example, Wisconsin annually spends over $10 million in state and SSBG funds for in-home services, which is twice the amount of funds we receive under Title III-B. Our state's lay advocate legal services system is inextricably involved with other access services, like outreach and public information; in addition our legislature is appropriating one million dollars in state general revenue for legal services for the elderly. Federal earmarking simply adds to the administrative paperwork and fiscal reporting required to sort out local service delivery patterns and fit them into the boxes selected by the Older Americans Act.

Question

9. The Committee is being told that priority services are not being funded by each area agency. What alternatives exist for ensuring that the priority services are carried out?

Reply

9. Congress could require state units on aging to annually report to the Commissioner on area agency compliance with this provision.

REAUTHORIZATION HEARINGS ON THE OLDER AMERICANS ACT
Part 1

MONDAY, MARCH 23, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 2216, Rayburn House Office Building, Hon. Dale E. Kildee presiding.

Members present: Representatives Kildee, Solarz, and Tauke.

Staff present: Susan Wilhelm, staff director; Thomas Kelley, legislative associate; Margaret Kajeckas, clerk; and Carol Lamb, minority legislative associate.

Mr. Kildee. The hearing will come to order.

The Subcommittee on Human Resources meets this morning for the second of three hearings on the reauthorization of the Older Americans Act.

I like to say wherever I go that I believe the Government's role is to promote, protect, defend and enhance human dignity. That is a very important principle. I try to examine every bill and proposal that comes before the Congress of the United States and ask myself that question: Will this promote, protect, defend and enhance human dignity?

I think that there are some groups in our society that really need Government more than others because they are perhaps more vulnerable than other groups. And those groups, of course, are the very young, the very old and the poor. The old are more vulnerable very often for a variety of reasons, such as economic or health reasons. Therefore, I always like to meet with those people who are working with the Congress in delivering these services to the very old.

We heard at our last hearing testimony from national groups representing nutrition providers, state agencies on aging, area agencies on aging and long-term ombudsman. The information reinforced the fact that the Older Americans Act and the programs it authorizes are among the most successful of any Federal programs currently operating.

For that reason, we are pleased to have with us today, Carol Fraser Fisk, the Commissioner on Aging, Elaine M. Brody, Associate Director of Research, Philadelphia Gerontology Center, and Congressman Ron Wyden will join us later to speak on behalf of an initiative he has introduced.

I welcome all our witnesses and look forward to your statements. I know Mr. Tauke will be here momentarily, and I will introduce him when he does come in.

Our first witness is the person who really has the direct charge, from the Executive Branch of Government, to carry out these administrative responsibilities. We look forward to working with her: Carol Frazer Fisk, United States Commissioner on Aging, Department of Health and Human Services.

Ms. Fisk, we welcome you here this morning.

STATEMENT OF CAROL FRASER FISK, COMMISSIONER ON AGING, ADMINISTRATION ON AGING, ACCOMPANIED BY DONALD SMITH, DIRECTOR OF MANAGEMENT AND POLICY

Ms. FISK. Thank you, Mr. Chairman. It is my pleasure to be with you this morning and to have an opportunity to talk about the reauthorization of the Older Americans Act of 1965. I am accompanied by Donald Smith of the Administration on Aging who is the Director of Management and Policy for our agency.

First, I want to assure you of both my personal commitment and that of this administration to a reauthorization that results in a strong, viable and responsive Older Americans Act.

I believe, as you have said, that the Older Americans Act passed by Congress more than 21 years ago this July is one of the most important and most successful pieces of legislation for older persons.

In 1965 the appropriation level was $7.5 million. In fiscal year 1987, appropriations total $724.5 million. This landmark piece of legislation provides grants to states to foster the development of comprehensive and coordinated service systems to serve older Americans in order to: "(1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate support of services; (2) remove individual and social barriers to economic and personal independence for older individuals; and, (3) provide a continuum of care for the vulnerable elderly."

As the Administration on Aging begins the third decade of our responsibility for administering the Older Americans Act, we are undertaking a critical examination of what has been accomplished and what remains to be done. We must operate within the framework of changing demographics of the elderly while still insuring that the nation's neediest older persons continue to receive the assistance they require to remain self-sufficient and independent within their communities.

Two critical issues are emerging which necessitate an intensive examination and reassessment of AoA programmatic and discretionary priorities now and in the years ahead. One challenge, of course, is the rapid growth of the elderly population. Between 1980 and the year 2000, the population age 60 and over is expected to increase approximately 27 percent and to represent 17 percent of the U.S. population. This figure may even climb to more than one in four persons by the year 2030—nearly 82 million older persons. This "graying" of American society will have significant impact on every major social institution—particularly social services—in the decades ahead.

A second major challenge will be to focus our increasingly scarce public resources on those older persons most in need of assistance. Frequently, these persons—the most vulnerable—are women, minorities, low income persons and the very old.

The Administration on Aging is undertaking more aggressive efforts to assist vulnerable older persons and their families in finding appropriate help to maintain their independence within their own communities and to delay or to prevent unnecessary institutionalization.

For this to occur, communities must take positive action to build integrated and responsive systems of care. AoA has undertaken the initiative to strengthen the role of states and area agencies on aging as catalysts, information referral centers and as brokers of services to help enhance, not replace individual self-sufficiency, family caregiving and other traditional forms of community support.

The building and strengthening of coordinating community service systems for the elderly and their families is the overall goal of the Administration on Aging. They want to assure that each and every community in this country is a good place to live and to mature.

I believe, Mr. Chairman, that the Administration's proposals for amending the Older Americans Act of 1965 will provide state and area agencies with the flexibility that will allow them to strengthen existing local systems, make the more visible, easily accessible, and responsive to the needs of older people, particularly the most vulnerable.

Now, I would like to describe some of the major features of the Administration's proposal for amending the Older Americans Act which we will submit to the Congress shortly. A full description of these proposals is contained in a more lengthy statement which has been distributed.

First, on the subject of the hold-harmless provision. Our draft bill would eliminate the hold-harmless provision which was enacted when it was anticipated that appropriations for each future year would exceed those for the proceeding year. Its apparent purpose was to prevent a state's allotment from declining while the Act's appropriations were increasing. This action would assure that funds are awarded in accordance with the actual aging demographics of our country.

Second, on state matching funds for the ombudsman program. Our draft bill would require states to provide 15 percent matching of Federal funding for long-term care ombudsman activities under the state plan. This is the same matching share that is required for all other state activity.

STATE PLANNING AND SERVICE AREAS

The draft bill would permit any state with the approval of the Commissioner become a state-wide area agency or the area agency for some or all of the state's planning and service areas.

REQUIRED ASSURANCE FOR EXPENDITURES ON SPECIFIED SERVICES

The draft bill would eliminate the requirement that area plans provide assurances that an adequate proportion of the area's funds for supportive services and senior centers will be expended for the delivery of specified priority services and would substitute a requirement to expend some funds for one or more of the priority services. Enactment of this proposal would again provide greater flexibility and discretion by allowing states and area agencies to shift their resources towards developing community or family service systems which would better serve the most vulnerable older people and their families.

TRANSFER OF FUNDS

The draft bill would increase the portion of allotments that states may transfer between the support of services and nutrition services sections of Title III from 30 percent under the current law to 50 percent for fiscal 1988, 60 percent for fiscal 1989 and 75 percent for fiscal year 1990. Enactment of this proposal would again allow states and area agencies greater flexibility and discretion using the Title III resources in response to the needs of older individuals.

DEMONSTRATION WAIVERS

Our draft bill would authorize the Commissioner to waive compliance with requirements of Sections 305, 306 and 307 of the Act relating to state program organization, area plans and state plans in the case of demonstration projects promoting the objectives of Title III.

Section 308(a)(1) of the Act currently provides state agencies with the authority to carry out demonstration projects of statewide significance relating to the initiation, expansion, or improvement of services assisted under Title III. However, state agencies are hampered from undertaking effective demonstrations of comprehensive and coordinated systems because of the various requirements in the law. If the Act provided the Commissioner with the authority to waive several of the current requirements, state and area agencies could begin to develop and demonstrate community service systems to appropriately sustain vulnerable older people in their communities and in their homes.

STATE PLAN ADMINISTRATION

Our draft bill would repeal the authority for states, upon application to the Commissioner, to use for state plan administration an additional three-quarters of one percent of their allotments under Title III for supportive and nutrition services.

This proposal would assure that funds are primarily used for the purposes intended; namely, the provision of nutrition and social services to the elderly.

MAINTENANCE OF EFFORT

Our draft bill would repeal the requirement that a state allotment for any fiscal year be reduced by the percentage by which its expenditures from state sources for that fiscal year are less than such expenditures for the preceding year. The requirement, as it is currently stated in the bill, has the unintended effect of discouraging one-time expansions of state programs in response to temporarily increased need or from non-renewable funding sources.

Let me turn just briefly to some proposed amendments for Title IV under the Training, Research, and Discretionary Projects and Programs. In our draft bill, we suggest language that would simplify and streamline the provisions authorizing training, research and discretionary programs under Title IV and eliminate barriers to participation by for-profit entities in activities under that title.

Our proposal would eliminate some of the elaborate, lengthy and duplicative descriptive materials that are included in Title IV as it is currently published.

Additionally, the removal of prohibition against the transfer of Title IV funds would allow for more effective coordination and cooperation of those Federal agencies or departments proposing to establish programs and services substantially related to the purposes of the Older Americans Act. This coordination and cooperation is already required under Section 203 of the Act.

Grants for Indian tribes. Our draft bill would repeal the provision requiring, as a condition of eligibility of an Indian tribal organization for grants under Title VI of the Act, that individuals to be served by the tribal organization not receive in the same year services under the state grant program of Title III of the Act.

The current law has an unintended effect. It can result in making ineligible for Title III services the older Indian who could be served by a Title VI grant but is not being served, or to make the older Indian who receives only one type of service under Title VI totally ineligible for any other services under Title III.

We believe this proposal would permit older Indians who are 60-plus and members of tribes which have received Title VI funds to gain a wider variety of services because they would be eligible to be served by Title III programs along with non-Indian older individuals who are eligible.

Having served in the aging network since 1972, I can see its progress and its maturity. It no longer requires the amount of Federal direction or intervention that it did 21 years or even 3 years ago.

Our proposals are consistent with the Administration's policy to place emphasis on services to those most in need, to maintain services, to provide for technical assistance and other supports to states and area agencies on aging.

Our proposals are also consistent with the policy to return decisionmaking to the levels closest to the people. This Administration is deeply committed to the improving the quality of life for all of this nation's older citizens. We appreciate this opportunity to share information about some of our efforts and to present our suggestions to you for improving and expanding the current provisions of the Older Americans Act to address the needs and concerns of older Americans now as well as into the future.

Mr. Chairman, this concludes my prepared summary remarks. As I said earlier, copies of my full statement have been distributed.

I would be happy to respond to any questions which you or other members of the subcommittee may have. Thank you.

[The prepared statement of Carol Fraser Fisk follows:]

PREPARED STATEMENT OF CAROL FRASER FISK, COMMISSIONER ON AGING, ADMINISTRATION ON AGING

Mr. Chairman and Members of the Subcommittee, I am pleased to have the opportunity to discuss with you today the reauthorization of the Older Americans Act of 1965. WE SUPPORT REAUTHORIZATION, AND I CAN ASSURE YOU OF BOTH MY PERSONAL COMMITMENT AND THAT OF THIS ADMINISTRATION TO A STRONG, VIABLE, AND RESPONSIVE OLDER AMERICANS ACT.

I believe that the Older Americans Act passed by the Congress more than 21 years ago this past July is one of the most important pieces of legislation for older persons ever passed. The Older Americans Act has been enormously successful in serving this nation's rapidly growing older population, and I am proud to have served in Older Americans Act funded programs since 1972.

In 1965 the appropriation level was only $7.5 million. In FY 1987, the Older Americans Act appropriations total $724.5 million. As you are aware, AoA annually awards grants to States to foster the development of comprehensive and coordinated service systems to serve older Americans in order to: "... (1) secure and maintain maximum independence and dignity in a home environment for older individuals capable of self-care with appropriate supportive services; (2) remove individual and social barriers to economic and personal independence for older individuals; and, (3) provide a continuum of care for the vulnerable elderly."

The Administration on Aging is very proud of the contributions made by the national network on aging to improve the quality of life for older Americans with both the supportive and nutrition services authorized by the Older Americans Act.

Title II of the Older Americans Act establishes the Administration on Aging (AoA) as the principal Federal agency for carrying out the provisions of the Act. This Title also describes the basic roles and functions of AoA. Chief among these are to administer the programs authorized by Congress under Titles III, IV, and VI of the Act, and to serve as an effective and visible advocate for older persons within the Department and with other agencies and organizations.

The Title III program has evolved from a relatively simple program of community service projects for older persons into a complex and highly differentiated "national network on aging" currently consisting of 57 State Agencies and 670 Area Agencies on Aging and more than 25,000 local nutrition and supportive service providers.

Not only do the State and Area Agencies on Aging use Title III monies to provide services but they also are instrumental in leveraging other public and private monies (for example, other State and local funds, private foundation contributions, and other Federal funds) in supporting the needs of older persons.

The Title III activities conducted in the States are based upon two, three, or four-year plans, as provided for by the 1981 amendments. Three separate Title III allocations are made to the States for (a) supportive services and senior center operations; (b) congregate nutrition services; and (c) home-delivered meals.

Each State makes awards to the Area Agencies, based upon their approved area plans, to pay up to 85 percent of the costs of supportive services and senior centers and for nutrition services. In most cases, Area Agencies then arrange with public, nonprofit, and/or proprietary service providers to deliver nutrition and other services described in the area plan. AAA's themselves monitor these services, plan for future needs and serve as advocates and leaders on behalf of all older persons in their planning and services area.

Before I begin our discussion on the reauthorization of the Older Americans Act, I would like to report on some of the leadership and advocacy activities of AoA. Many of the ideas and experiences gained from these activities have been used to develop the legislative proposals that I will share with you today.

As AoA begins the third decade of administering the OAA, we are undertaking a critical examination of not only what has been accomplished but also what remains to be done. We must operate within the framework of the changing demographics of the elderly (as well as of the families of which they are a part) while still ensuring that the nation's neediest elderly persons continue to receive the assistance they require to remain self-sufficient and independent within their own communities.

Two critical issues are emerging which necessitate an intensive examination and reassessment of AoA programmatic and discretionary priorities now and in the years ahead. One challenge, of course, is the rapid growth of the elderly population. Between 1980 - 2000, the population age 60 and over is expected to increase approximately 27 percent and to represent 17 percent of the U.S. population. This may climb to more than one in four persons by the year 2030 -- nearly 82 million older persons. This "graying" of American society will have a significant impact upon every major social institution -- particularly social services -- in the decades ahead.

A second major challenge will be to focus our increasingly scarce public resources on those older persons most in need of assistance. Frequently, these persons -- the most vulnerable -- are women, minorities, low income persons, and the very old.

Beginning FY 1986, and for the next several years, the Administration on Aging is embarking upon more aggressive efforts to assist vulnerable older persons and their families in finding appropriate help to maintain their independence within their own communities and to delay or prevent unnecessary institutionalization.

For this to occur, Mr. Chairman, I believe communities must take positive action to build integrated and responsive systems of care. The Area Agency on Aging is the key organization that must continue to forge linkages with and between existing systems of services within each community in their area of responsibility and where necessary, provide leadership in helping communities develop new services, organizations and linkages. AoA is working with State and Area Agencies on Aging to strengthen efforts that will build a system of services to provide a continuum of care for older persons within each American community. Each system must, in turn, be tailored to meet the special needs, circumstances and resources of each individual community.

For example, in order to help States and Area Agencies in the development of responsive community-based systems, AoA has developed a guide. This guide can be used by leaders and citizens of every community in the nation to assess their local systems and to determine if current systems at the local level are responsive to the needs of older people. The guide can be a useful tool in heightening awareness of community responsibility for the special needs of the elderly and of the necessity of forging systems of care that are appropriate to an individual elderly person's needs, capacities and resources.

To meet the challenges facing it, AoA is committed to working for increased responsiveness by families, States and communities, service providers, and the private sector to the current and future needs of older Americans. In addition, AoA is committed to building more positive attitudes and perceptions of aging and the aged.

Two of AoA's most important priorities in fiscal years 1986-89 are:

(1) to assist families in their efforts to care for older relatives, particularly the most vulnerable and frail, and to help maintain these older persons in their homes and communities as long as possible; and

(2) to assist States and communities in their efforts to develop and improve community-based systems of care that are accessible, appropriate, responsive, cost-effective and humane.

To achieve these priorities, AoA will initiate, encourage and supplement activities designed to help Area Agencies on Aging:

- increase their visibility to those who most need access to services and to serve as a catalyst and broker of services to the elderly in their own communities;
- serve as a focal point for coordinating aging service within communities, working with other systems to hel provide a continuum of care and tailoring local service systems to meet the needs and special circumstances; and

- improve the targeting of services to the most vulnerable and frail elderly and their families in order to help communities serve as many older persons as possible to remain independent and self-sufficient for as long as possible.

The strategies which AoA will use to accomplish the long-range objectives and program priorities include:

- strengthening linkages with and between other agencies at all levels, both public and private, which serve the elderly;
- increasing transfer of knowledge about models of family and community-based care systems to appropriate organizations and service providers;
- heightening public awareness of the role individuals play in determining their own health; and
- promoting public awareness in a variety of areas, including the availability of State and local aging services agencies to help older persons.

Toward this end, AoA has developed and implemented a variety of special initiatives aimed at improving the quality of life for older people. Examples of special initiatives are as follows:

- Two years ago the Administration on Aging launched a national initiative to assist State Agencies on Aging to develop and implement strategies to increase minority participation in Older Americans Act programs. This initiative was undertaken in cooperation with the State Agencies on Aging, Regional AoA Offices and four national minority organizations: Asociacion Nacional Pro Personas Mayores; National Center on Black Aged; National Pacific/Asian Resources Center on Aging; and the National Indian Council on Aging.

  In addition, each State was asked to prepare an action plan which described steps the State proposed to take through FY 1985 to increase minority participation. A summary of models for minority participation activities was transmitted by AoA to the aging network and we expect the States to replicate some of these models.

- AoA has long realized the need for the systematic sharing of technical information among members of the aging network about projects and efforts which benefit older people. During FY 1986 AoA began publication of Aging Program Notes, which is regularly sent to the aging network and features descriptions of success stories from State and Area Agencies on Aging that have demonstrated their effectiveness as focal points in their communities.

- As part of its plans for more aggressive efforts in assisting vulnerable older persons and their families, AoA has also realized that the aging network needs to be more visible. During FY 1986, AoA completed two tasks which will bring about greater visibility of State and Area Agencies on Aging. As many of you may recall, AoA forwarded to Senators and Congressmen a list of their State and Area Agencies on Aging and asked them to tell those who are concerned about older people that the State and Area Agencies on Aging are there to help. We urged them to contact their respective State and Area Agencies on Aging with questions about services and programs for older people. In addition, AoA worked with the the Social Security Administration to distribute copies of the

AoA Directory of State and Area Agencies on Aging to each of its district offices. This will encourage appropriate referrals to services to take place for older persons, their family members and caregivers.

- Recognizing the personal and societal benefits of healthier lifestyles for older persons, AoA and the Public Health Service (PHS) have undertaken a multiyear effort to encourage States and local communities to develop ongoing health promotion and wellness activities for older Americans. The goals of the initiative include: (1) enhancing the quality of life for older Americans through improvement of their health status; (2) focusing attention on health promotion and disease prevention, especially in the areas of injury control, nutrition, physical fitness, and drug management; and (3) reducing health care costs caused by preventable conditions. This initiative also incorporates a commitment between PHS and AoA to ensure a gerontological focus in the curricula of various health care professionals in order to prepare the health community of this nation for the graying of America.

- Under its multiyear Alzheimer's disease initiative, the Administration on Aging has supported several research and demonstration projects designed to develop and strengthen family and community-based care for Alzheimer's disease victims. AoA also has joined with other Federal agencies in coordinating our current and planned discretionary program efforts aimed at meeting the supportive service needs of Alzheimer's disease patients and their families. This includes collaboration with the National Institute of Mental Health in sharing information about respective demonstration and research program activities in the field of Alzheimer's disease to minimize duplication in efforts to strengthen family and community supports, as well as collaboration with the National Institute on Aging to exchange information on current and planned efforts for Alzheimer's disease patients and their families. AoA consequently included a special priority area for demonstration grants under the FY 1987 OHDS Coordinated Discretionary Funds Program designed to strengthen the leadership capacity of State Agencies on Aging to assist Alzheimer's disease victims and their families. It should be noted that while many persons with dementia are served and will be served by these research efforts, many more are served through the regular programming of Title III.

- During FY 1986, AoA actively promoted and disseminated information about home equity conversion for State and Area Agencies on Aging and other organizations interested in the elderly. Efforts were made to identify useful home equity conversion products, disseminate useful products and materials, sponsor workshops at the regional level to promote interest, and provide technical assistance to potential home equity conversion sponsors. Under this initiative several new products were distributed. These include: the proceedings from "The Future is Now--A Home Equity Conversion Conference", jointly sponsored by the Department of Housing and Urban Development, the Federal Council on the Aging and AoA, and An Attorney's Guide to Home Equity Conversion, designed to facilitate research by attorneys regarding legal issues involved with home equity conversion, developed by the American Bar Association under a grant from AoA. The guide was distributed to several groups including legal services attorneys and private attorneys who serve older people and others. A manual, Home Equity Conversion--Information and Actions for the Aging Network, also was disseminated to AoA Regional Offices.

- In FY 1986, AoA awarded nine (9) new grants to demonstrate Statewide collaborative activities to prevent and treat elder abuse. As part of the work being undertaken through these projects, State and Area Agencies on Aging and State adult protective service agencies are working with the courts, law enforcement officials, consumer protection agencies and voluntary groups to: (1) conduct public awareness campaigns to recognize and prevent elder abuse; and (2) coordinate action for intervening and following up on elder abuse reports. The projects will produce various "how-to" manuals, video tapes, training conferences, public service spot announcements for radio and television broadcasting, publicity and informational materials, and model Tribal codes.

- As part of AoA's strategy to target services to the vulnerable elderly, the Agency has launched an initiative to improve the capacity of caregivers who provide critical assistance to functionally impaired older persons. This initiative is based on the recognition that growing numbers of vulnerable older persons in this country are cared for in their homes by family, friends, and neighbors, and that these caregivers often have insufficient information, training, and support to perform their roles in a fully effective manner. During FY 1986, AoA funded 22 research and demonstration projects to develop model Statewide and local dissemination campaigns to inform and educate caregivers about the most useful ways of carrying out their difficult tasks. The projects will implement 19 Statewide and 23 local campaigns using television, film, videotapes and telecommunications in innovative ways to reach the broadest possible audience. A project funded in FY 1985 established a national newsletter for caregivers called Parent Care. Over 600 paid subscriptions had been received by the end of FY 1986 and the project expects to become self-sufficient during FY 1987. As part of the caregiver initiative and AoA's long-term care activities, AoA developed a generic caregiver brochure. This brochure is designed to provide information to informal caregivers of vulnerable older people - particularly to caregivers and concerned relatives who may live in a different part of the country than the older person. We have been working with a large number of private sector groups to have them reproduce and distribute this guide.

AoA has not been alone in working to improve the lives of older Americans. The 1981 and 1984 Amendments to the Act provided greater flexibility to State Agencies on Aging, and they have begun to use that flexibility.

For example, State Agencies on Aging used Title III-B (Supportive Services) funds and funds from other sources to establish and maintain long-term care ombudsman programs at the State and sub-State levels. Additionally, through their ombudsman programs, States have addressed such issues as nursing home regulations, abuse of residents' personal funds, and restrictions on access to nursing homes. During FY 1986, complaint statistics and ombudsman program data for the FY 1985 reporting period were analyzed. Some highlights of these data are as follows:

- The number of sub-State ombudsman programs reported by States continues to increase. During FY 1985, the most recent period for which data are available, there was a net increase of 53 local or regional ombudsman programs, increasing the nationwide total from 679 in FY 1984 to 732 in FY 1985.
- Total funding for State and local ombudsman programs in FY 1985 was about $18.5 million, an increase of 29 percent over FY 1984. In addition to Title III-B funds, State and local governments used funds from other sources, including State, county, and local revenues and other funding sources.
- Nationwide, over 3,900 people worked in State and local ombudsman programs during 1985, including professional and volunteer staff.

Data on Title III services and program operations are sent to the Administration on Aging each year by the State Agencies on Aging through the Title III Information System. During FY 1986 the Title III Program Performance Reports for FY 1985 were analyzed. Selected program data are highlighted below.

- The Title III-B program is currently reaching an estimated nine (9) million older clients in need of access, in-home and community-based services.
- In FY 1985, 16.4 percent of all participants were racial and ethnic minorities and 43 percent were low income.
- In the area of access services, transportation was the most frequently provided service, followed by information and referral and outreach. Of four defined in-home service categories, reassurance to elderly persons through visiting and telephone contacts was reported most frequently, followed by homemaker, chore and home health aid services. Of the four service categories reported in the Title III Information System, health services were most frequently provided, followed by legal, escort and residential repair/renovation services.

- Over 149 million congregate meals were served to older people and their spouses during FY 1985. In addition to Title III funds, these meals are also supported by State funds, Social Services Block Grant and other Federal funds, State and local funds and participant contributions. Over 2.9 million elderly received meals at congregate sites. During FY 1985, 75.5 million meals were provided to the homebound elderly from all funding sources. Approximately 670,000 older persons received these meals.

Under Title VI of the Older Americans Act, the Administration on Aging annually awards grants to Federally recognized Indian Tribes. These grants assist Tribal Governments in delivering nutrition and supportive services to older Indians. In FY 1986, the number of Tribes funded under Title VI increased from 125 to 133.

In January 1986, Regional Offices of the Administration on Aging were authorized to serve as the primary point of contact for Indian leaders operating programs for the elderly. By virtue of long experience with Older Americans Act programs, familiarity with community resources and geographic proximity, the Regional Offices have successfully provided management assistance and opportunities for collaboration between Indian leaders and State officials working in the field of aging.

During FY 1986, Title VI service data were analyzed for the FY 1985 funding period. Preliminary analysis of the data reflects the following:

- The Title VI program continues to maintain a very high participation rate. Of the eligible population of 28,417, about 90 percent participated in nutrition services and about 60 percent received one or more supportive services.
- About 70 percent of the older Indians participating in nutrition services received their meals in a congregate setting, while 30 percent received their meals at home.
- Title VI provides a wide variety of supportive services. The two services most frequently used are transportation and information and referral.
- The Title VI program attracts a large number of volunteers (about 60 percent of staff) to assist with the program.

- o The level of effort continues to be directed primarily toward nutrition services. Approximately 60 percent of Tribes' total expenditures are for meals.

Title IV of the Older Americans Act authorizes a program of discretionary grants and contracts to support training and education, research and demonstration and other activities. A total of $23,925,000 was available to support those efforts during FY 1986. Over the next three years AoA will encourage and fund Title IV activities that will further assist State and Area Agencies on Aging in the development of more coordinated comprehensive and responsive systems dedicated to helping older individuals to remain independent in their communities. AoA's goals for these activities are outlined below.

- o Assessments of Community Service Systems and the Roles of Area Agencies on Aging -- Improvement in community-level service delivery systems for the elderly is a key priority for AoA over the next three years. An instrument which assesses both the status of community service systems and the roles of Area Agencies on Aging in furthering their development was produced several years ago. However, it has not been widely used and there is, consequently, only anecdotal information on these topics. Through the FY 1987 Coordinated Discretionary Program announcement, AoA plans to fund multi-site demonstrations in several States to encourage State Units on Aging to begin obtaining information on the adequacy of community-level service systems and the activities of Area Agencies on Aging.

- Development of Measures for Assessing the Performance of State Agencies on Aging -- Agreed-upon measures that can be used by State Units on Aging to evaluate how well they are carrying out their major responsibilities do not currently exist. One priority area in the FY 1987 Coordinated Discretionary Program announcement calls for the development and field testing of just such a self-assessment instrument. What is envisioned is a protocol that can be self-administered and that compels critical analysis of the strengths and weaknesses of State Units on Aging in the performance of their most important functions. Developmental work in this area should result in an instrument which is applicable to all States and which will be sufficiently easy to use so as not to discourage voluntary application on the part of State Agencies interested in formal self-evaluation.

- Measurement of Comprehensive Community Based Systems-Building Efforts of State Units on Aging and Area Agencies on Aging -- Under an award issued in September 1986, the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (NAAAA) will develop a recommended approach for measuring and reporting data on the incidence of community service system-building activities carried out by State and Area Agencies on Aging. NASUA and NAAAA will prepare and field test a set of terms and procedures for reporting information on this area, and will eventually provide a national data service for AoA and others by analyzing the indicators of community systems-building efforts on an ongoing basis.

As you can see, AoA has undertaken the initiative to strengthen the roles of State and Area Agencies on Aging -- as catalysts, information and referral centers and as brokers of services -- to help enhance, not replace, individual self-sufficiency, family care-giving and other traditional forms of community support. The building and strengthening of coordinated community services systems for the elderly and their families is the overall goal of AoA. I believe, Mr. Chairman, that the Administration's proposals for amending the Older Americans Act of 1965 will provide State and Area agencies with the flexibility that will allow them to strengthen existing local systems to make them more visible, easily accessible and responsive to the needs of older Americans, particularly the most vulnerable.

I would now like to describe some of the major features of the Administration's proposals for amending the Older Americans Act of 1965, which we will be submitting to Congress shortly.

AMENDMENTS TO TITLE II

APPOINTMENTS TO FEDERAL COUNCIL ON THE AGING

The draft bill would restore, for FY 1988 and succeeding fiscal years, the procedure in effect prior to enactment of P.L. 98-459, the Older Americans Act Amendments of 1984, under which appointments to the Federal Council on the Aging are made by the President with the advice and consent of the Senate.

The major purpose of the Council is to advise and assist the President on matters relating to the special needs of older Americans. Therefore, it is wholly appropriate, as in other matters, that those who will advise and assist the President be appointed by the incumbent of the office.

AMENDMENTS TO TITLE III

HOLD-HARMLESS

The draft bill would eliminate the hold-harmless provision of the Older Americans Act which was enacted when it was anticipated that appropriations for each future year would exceed those for the preceding year. Its apparent purpose was to prevent a State's allotment from declining while the Act's appropriations were increasing.

Even in years when it was possible to comply with this requirement, its effect was not desirable, because it required continuance of allotments to some States based on past instead of present realities.

STATE MATCHING FUNDS FOR OMBUDSMAN PROGRAM

The draft bill would require States to provide 15 percent matching of Federal funding for long term care ombudsman activities under the State plan (the same matching share as is required for all other State administrative activities).

A State's use of Title III funds for its ombudsman program is the only use for which matching non-Federal funds are not specifically required. There are grounds for believing that this result was never intended and that it was an oversight to fail to require matching for this use of funds. State and Area Agencies are already expending in excess of $8 million in State and local funds for ombudsman activities. The demand for long-term care services will continue to increase and this proposal would serve to support the continued growth of ombudsman activities.

STATE PLANNING AND SERVICE AREAS

The draft bill would amend the provision permitting a State agency to function as an area agency. Under prior law, certain States, prior to October 1980, had obtained the approval of the Commissioner on Aging to designate the entire State as a single planning and service area, and to act as the area agency for the single area. Current law permits only those States to designate additional planning and service areas administered by other Area Agencies, and to continue to function as the area agency for the balance of the State. This section of the draft bill would permit any State, with the approval of the Commissioner, to become a Statewide area agency, or the area agency for some or all of the State's planning and service areas.

This proposal would provide States with the flexibility and capacity to develop more cost-effective methods for the administration of Older Americans Act programs, and to carry out more efficiently their responsibilities to evaluate the need for supportive, nutrition and senior center services within the State and determine the extent to which existing public or private programs meet such needs.

REQUIRED ASSURANCES FOR EXPENDITURES ON SPECIFIED SERVICES

The draft bill would eliminate the requirement that area plans provide assurances that an "adequate proportion" of the area's funds for supportive services and senior centers will be expended for the delivery of specified priority services (access services, in-home services, and legal assistance), and would substitute a requirement to expend some funds for one or more of the priority services. This section would also make a conforming amendment to eliminate the related requirement that the area agency conduct a public hearing and obtain a waiver from the State agency before failing to expend funds for any priority service.

Enactment of this proposal would provide greater flexibility and discretion by allowing State and Area Agencies on Aging to shift more of their resources toward developing community or family service systems which would better serve the most vulnerable elderly and their families. The proposed amendment would permit States to capitalize on the characteristics of the existing service system in each planning and service area, to fill service gaps, and to more effectively coordinate with other funding sources, both public and private.

COORDINATION OF COMMUNITY-BASED SERVICES

The draft bill would require State plans to provide assurances that Area Agencies will facilitate the coordination of community-based services to older individuals residing at home, in hospitals, or long-term care facilities, who are at risk of institutionalization but who could remain in or be returned to the community if community-based services were available.

Coordination of home and community-based services for the vulnerable elderly has become an increasingly important service priority that should be a State plan requirement and a mandated area agency activity. Area agencies are in a unique position to provide leadership in coordinating the wide range of health and social services needed by vulnerable elderly persons to remain in the community.

TRANSFER OF SUPPORTIVE AND NUTRITION SERVICES FUNDS

The draft bill would increase the portion of allotments that States may transfer between the supportive services and nutrition services programs from 30 percent under current law to 50 percent for FY 1988, 60 percent for FY 1989, and 75 percent for FY 1990.

Although some States have used the flexibility provided in the 1984 amendments to transfer funds between parts, enactment of this proposal would provide greater flexibility and discretion and would allow State and Area Agencies on Aging to (1) develop community or family service systems which better serve the vulnerable elderly and their families, (2) encourage all relevant agencies to continue and increase the redirection of resources to serve the most vulnerable elderly, and (3) provide State and Area Agencies on Aging with a clear message that flexibility is intended and allowed in the development of new and alternative ways of coordinating and building comprehensive service delivery systems to address the needs of older individuals.

DEMONSTRATION WAIVERS

The draft bill would authorize the Commissioner to waive compliance with any requirements of sections 305, 306, and 307 of the Act (relating to State program organization, area plans, and State plans) in the case of demonstration projects promoting the objectives of Title III.

Section 308(a)(1) of the Act currently provides State agencies with the authority to carry out demonstration projects of Statewide significance relating to the initiation, expansion, or improvement of services assisted under title III. However, State agencies are hampered from undertaking effective demonstrations of comprehensive and coordinated systems because of the various requirements in the current law. Further, various provisions of the Act preclude State agencies from developing viable demonstration models that do not conform to the planning and service area/area agency service delivery model currently required by the Act. If the Act provided the Commissioner with the authority to waive several of the current requirements that are associated with the planning and service area/area agency service delivery model, State and Area Agencies could begin to develop and demonstrate community service systems to appropriately sustain vulnerable older people in their communities and in their homes.

STATE PLAN ADMINISTRATION

The draft bill would repeal the authority for States, upon application to the Commissioner, to use for State plan administration an additional three-fourths of one percent of their allotments under Title III for supportive and nutrition services.

The proposal would ensure that funds are primarily used for the purpose intended, namely the provision of nutrition and social services to the elderly.

MAINTENANCE OF EFFORT REQUIREMENT

The draft bill would repeal the requirement that a State's allotment for any fiscal year be reduced by the percentage by which its expenditures from State sources for that fiscal year are less than such expenditures for the preceding fiscal year. This requirement has the unintended effect of discouraging one-time expansions of State programs in response to temporarily increased need or from nonrenewable funding sources.

The maintenance of effort concept in section 309 of the Act has served as a disincentive to States for using one time funds available to them for the purpose of improving services and systems funded in whole or in part with Older Americans Act funds. We do not think that the statutory requirement in section 309(c) was intended to penalize States that choose to increase their expenditures from State sources above those amounts required for the non-Federal share applicable to allotments received under Title III.

AMENDMENTS TO TITLE IV

TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS

The draft bill would simplify and streamline the provisions authorizing training, research, and discretionary programs and projects under Title IV of the Act, and would eliminate barriers to participation by for-profit entities in activities under that title.

As it presently reads, Title IV is restrictive. The proposal would eliminate the elaborate, verbose description of areas of innovation to which the Commissioner must give special consideration in making demonstration project (model project) grants. It would also enhance the capacity of State and Area Agencies on Aging to assure the development of local service delivery systems that assist in the provision of family and community based care.

There may have been justification for separate sections on these subjects when these sections were added to Title IV in 1978. However, the special emphasis provided by these sections has served its purpose. Any additional attention these subjects might need could still be given under the general demonstration project authorization.

The removal of the prohibition against the transfer of Title IV funds would allow for more effective coordination and cooperation with those Federal agencies or departments proposing to establish programs and services substantially related to the purposes of the Older Americans Act. This coordination and cooperation is required under section 203 of the Act.

AMENDMENTS TO TITLE VI

GRANTS FOR INDIAN TRIBES

The draft bill would repeal the provision requiring, as a condition of eligibility of an Indian tribal organization for a grant under Title VI of the Act, that individuals to be served by the Tribal organization not receive in the same year services under the State grant program under Title III of the Act.

The current law also has an unintended effect. It can result in making ineligible for Title III services an older Indian who could be served by a Title VI grant but is not being served, or to make the older Indian who receives only one type of service under Title VI ineligible for any other services under Title III.

This proposal would permit older Indians who are 60-plus and members of tribes which have received Title VI funds, but who may not be served by programs conducted with those funds, or who may not be fully served by such programs, eligible to be served by Title III programs along with non-Indian older individuals who are eligible. This change would also assist tribal organizations and Area Agencies to broaden the scope of their cooperation in developing more comprehensive service delivery systems.

REPEAL OF TITLE VII

OLDER AMERICANS PERSONAL HEALTH EDUCATION AND TRAINING PROGRAM

The draft bill would repeal the Older Americans Personal Health Education and Training Program under Title VII of the Act. This authority, which has never been funded, duplicates other programs addressing the same needs.

Since Title VII was added to the Act in 1984, no funds for that title have been appropriated. Recent surveys conducted by the AoA Regional Offices indicate that at least $4.6 million is currently being expended in this area from titles III and IV funds and State, local and private sources. These dollar figures were compiled with only 40 States reporting data and nine of these States could not provide dollar information. Since more than adequate emphasis is already being given, without Title VII, to health and nutrition education for the elderly, no useful purpose is served by retaining the title in the Act.

In summary, the "AGING NETWORK" has come of age, and in our opinion does not require the amount of Federal direction or intervention it did 21 or even three years ago. The proposals are consistent with the Administration's policies to place emphasis on services to those most in need, to maintain services, and to provide for technical assistance and other support to State and Area Agencies on Aging. These proposals are also consistent with the policy to return decision-making to the level nearest the people.

This Administration is deeply committed to improving the quality of life for all of this nation's older citizens. We appreciate this opportunity to share information about some of our efforts, and to present our suggestions for improving and expanding the current provisions of the Older Americans Act to address the needs and concerns of older Americans now, as well as in the future. Mr. Chairman, this concludes my prepared remarks. I will be happy to respond to any questions which you or any of the other subcommittee members may have.

Mr. **Kildee**. Thank you very much, Madame Commissioner, for your testimony. One thing that caught my attention quickly was your suggested change on Indian eligibility. We will work closely with you to try to find some remedy for that. One of the first responsibilities I undertook when I came to the Congress was to work with the Indian people of this country. I think your suggestion is one that we can get together on and find a solution for. I appreciate that and I appreciate your testimony in general

Perhaps before we get started, Mr. Tauke would like to make an opening statement.

Mr. **Tauke**. Well, I apologize for being tardy and missing the first part of your testimony, but we certainly want to welcome you to the Subcommittee, and we look forward to working with you closely during the next several months as we move through the reauthorization process. We commend you for your work with the Commission and are anxious to move forward in our common goal of better serving older Americans.

Ms. **Fisk**. Thank you.

Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you, Tom.

Commissioner, the subcommittee has been requested by the Area Agency on Aging Association to consider an amendment that would permit Area Agencies on Aging to provide case management as an access service without seeking a waiver from the state as required under existing law.

Could you comment on that, and what would your view be on such a proposal?

Ms. **Fisk**. Well, it is not—that is not a component of the Administration's bill, so, my position that I express to you then in response to your question is from a personal view. I feel very strongly that no action should be taken that would diminish the critical role of states and area agencies as catalysts and brokers on behalf of all older people.

I think the decision to allow direct service to be provided by an area agency is more properly addressed through the waiver procedure as is currently written in the Older Americans Act. I think it should be up to each individual state to determine what is the proper role and if any variation should be undertaken from the current law.

I am deeply concerned about any action that diminishes the responsibilities of states, area agencies or the Administration on Aging from being an advocate for all older people. And I would hope that you would take that point into consideration as you consider that other proposal.

Mr. **Kildee**. Thank you, Commissioner.

The subcommittee has been asked also to consider amendments that establish a 6 percent set-aside for each Title III-B priority service. What effect do you think this proposal might have?

Ms. **Fisk**. It would be difficult for me to comment on the exact 6 percent set-aside. However, again, I feel that it is most appropriate for each individual state to make decision on priority services and the dollars amount to be spent for each one of those services.

As you know, each state is different and therefore the discretion of the State Office on Aging and the State Director can play a major part in assuring that the way the dollars are spent is most responsive to the unique needs of the older persons in that state.

I would suggest that the Members of Congress consider the expertise of the state and the State Director in making those types of choices and allow the state the flexibility that it needs by not putting any specific percentage into the bill.

Mr. Kildee. As you are aware, the reauthorization bill that I introduced recently proposes a new authorization for $25 million for in-home services for the frail elderly. The committee also expects to consider another proposal authorizing services specific for victims of Alzheimer's disease and their families.

What is the Department's view on making more funds available for in-home services for those who are in need but not eligible under other Federal, state or local programs?

Ms. Fisk. Well, certainly, I think we can agree among ourselves, there will never be enough dollars to address the victim of Alzheimer's or the pressures that are on their families, or to respond to the issues of older people who are frail in our communities throughout this country.

I would suggest that, again, the best way to make these dollars should someone wish to make additional dollars available is to do so in a way that allows the each individual state to make the tough choices about priority spending. It may indeed be that in some states there is a high percentage of need for Alzheimer's victims. Quite likely, then, in other states, there may be other subject areas or program areas that need to be addressed.

I would argue, again, for the maximum amount of state flexibility to be given so that the state could make decision about the use of any additional dollars.

Mr. Kildee. I guess that is the age-old question here in Washington and not just on this bill, but any bills.

Ms. Fisk. Right.

Mr. Kildee. For example, with regard to Education bills, we must ask how much do we direct the dollars and how much do we leave to the discretion of the individual states. On certain issues, I seek flexibility. On other issues, I seek direction. I guess it depends on the situation at the time and one's own attitude at the time.

Ms. Fisk. Certainly.

If I might add, with all due respect, I believe that the governors and their appointed directors are extremely sensitive to the needs of older people in each one of their individual states and it is the variation because of the nature of each state that I believe we wish to protect and thereby would again suggest to you that should additional funds be made available that the governor be allowed that latitude to determine where they would be best spent in accordance with the need of the older people in his state or her state.

Mr. Kildee. One of the problems very often is that with only limited funds available it makes it difficult for us to make choices. And sometimes the choices are rather cruel. It would help if we could have a separate authorization and have some assurances, perhaps that would not diminish one area in order to get some extra dollars for the new authorization. The $25 million here would provide some additional dollars, then, for a category that is a growing group of people in this country.

Ms. Fisk. I think the states have done a very good job of making those kinds of adjustments. And if you look at the statistics that we keep in terms of the amount of dollars that are reallocated among the various components of Title III, you will see a $21 million adjustment or shifting within those priority areas that indeed reflects exactly the kind of shifting that you might be looking for.

We are seeing dollars flow into the in-home or supportive services area. We are seeing dollars flow into the home-delivered meals. So, I think there is proof positive in the behavior of the states thus far and I dare say into the future that they are very sensitive to this issue and would use those dollars in a way that would respond to the most vulnerable older population in the state.

Mr. Kildee. I really appreciated this dialogue because I know both of us are search as far as the manner in which to serve people better. One of the problems, perhaps is that the frail elderly very often suffer even a greater isolation and because of that are not brought to the attention of agencies or come to the attention of agencies. And, perhaps, if we had some money set aside just for them, it might nudge various agencies to go out and seek those people out.

Ms. Fisk. I think part of the answer lies in additional resources to nudge agencies. We think also that part of the answer lies in better educational efforts. Our mail and our phone inquiries form the middle-aged caregivers have jumped dramatically, which it should not surprise us, but it becomes quite interesting to see that the bulk of our calls these days, the bulk of our letters are coming from the middle-aged child who is seeking assistance for an older family member, primarily someone who is a long distance away.

So, while we are sensitive to the needs, obviously, the need for additional resources might be the case in local communities, we have also put major effort on the educational side. We have prepared a generic guidebook that helps a loved one advocate for an older person, older loved one across the miles. This book is a generic guide on where to turn for help, and it might help the young man whose mother happens to be in Albuquerque and he is at work here know how to find his way through the service system even long distance.

What we have done with our limited dollars is produce the sample, if you will, and we will make available to anyone who wishes to print and distribute a camera-ready version. In fact, should the Committee wish to print and put its logo on the front, we would be delighted to have you do so.

Also, we think that the isolation is certainly a critical factor. And our programs are very much involved in trying to do more outreach; but we think also aiming at the middle-aged caregiver who is struggling with this problem though perhaps not in such a detailed discussion as we are having this morning, but is struggling to even find their way to our service system. We think more efforts are needed on that side and we think that this is just a step in the right direction.

Mr. Kildee. I think it is a good step. The increasing mobility of our society has been going on for quite some time. It is not a new phenomena, but I think it is accelerated. More and more, you find parents and their grown children living miles and miles from one another. For a good number of years, it may have been common for them to live in the same community. But I think there is an acceleration of that now, both because children move and very often because the elderly, when they are still relatively healthy, move. And then become frail after that. So, there are various reasons for the separation and mobility of both generations that have increased, I believe, to a good extent.

I have some more questions, but my five minutes are up and I will turn to Mr. Tauke right now.

Mr. TAUKE. Could you give us a copy of the booklet that you just held up?

Ms. FISK. Oh, I would be happy to. I would also—you would also find that I have a fairly aggressive sales staff. That is to say, all the AoA staff members. And once I give you a sample, someone will follow up in the hopes that you are going to print and distribute. I will be happy to do that.

Mr. TAUKE. Thank you. During the course of discussions that I have had with senior citizens over the years about the Older Americans Act, one of the issues that has occasionally arisen is the question of the growing bureaucracy associated with the Older Americans Act. Do you have any information about how many of the dollars that are appropriated under this Act go for services and how much go for administration?

Ms. FISK. The bulk of the dollars, of course, do go into services. Each state is allowed five percent or $300,000, whichever is the greater to be used for administration of the state plan. I do no remember the figure exactly. It is here in this massive book because we just did get the actual figure. Let me see if Mr. Smith has it. It is about $30 million that he has indicated here. States do not use up to the level allowed in terms of administration of these plans. In fact, many states fall far below that level of five percent or 300,000, whichever is greater. I regret that older people do see that, and, certainly, I have had similar conversations as you describe. But I would come quickly to defend the states and area agencies and the Administration on Aging and say that we are constantly mindful that the top priority is the work to build community systems to make each and every community responsive and to provide services and attempt to always be as efficient as we can.

Mr. TAUKE. Part of the difficulty may appear to be with the Area Agencies on Aging, that the Area Agencies on Aging serve a coordinating function but do not themselves provide services. I just came from a meeting in the past few weeks that causes me to raise this question. Often times the question is raised: Why do we need to have this second layer of bureaucracy in there? They are not providing the services. Why do states not just contract directly with the service providers rather than have the money go from the state to the area agencies and then to the people who are providing the services? Do you have any observations you would care to share about that?

Ms. FISK. I certainly do. I think that the Area Agencies—and that is where I started working in the field of aging. So, I am very biased. I think Area Agencies have a major role to play as the key information and referral center, as the group, the organization that has the responsibility and the opportunity to help bring the pieces together, if you will, at the front line for older people. The Area Agency role as a catalyst, as a monitor, as a stimulator is critical.

If we look at what is happening in our country in terms of increased number of older peoples and, unfortunately, increased confusion, I think that that role of catalyst, broker and provider of information and referral services has become more and more critical.

As we look at the increased number of resources that we will probably have in changing service delivery systems in each and every community in this country as a result of some expenditure for catastrophic illness, I submit to you that that role, that special non-competitive role of an Area Agency on Aging will become more and more critical and needs to be solidified, reaffirmed, as it has been in past reauthorizations of the Older Americans Act.

Quite the contrary. I think that that—if you want to call it a layer, I think it is an essential role that must be played and we will lose tremendously in this country if we do not strengthen that role. I would oppose any actions that would weaken that role.

Mr. TAUKE. Do you have any statistics that would indicate to us how many employees are employed by the Area Agencies on Aging?

Ms. FISK. We do. I do not have them with me, but, yes, we do have that.

Mr. TAUKE. Could you give us an indication as to how that compares with what it was two years, three years and four years ago?

Ms. FISK. We would be happy to, yes.

Mr. TAUKE. First of all, I am not anti-Area Agency on Aging. I am pro-Area Agency on Aging. I want to get my ducks in a row when confronted on these issues. And the strong perception in my area apparently is that, for example, in transportation, as the transportation services have declined, the number of people administering transportation services has increased. And the senior citizen—some of the self-appointed advocates, maybe, of senior citizens say, "If you just get the bureaucracy out of the way, we would have plenty of transportation."

Ms. FISK. It is a legitimate question and one that we must be prepared to answer. Absolutely.

Mr. TAUKE. The funding transfer authority is another issue that you brought up that I would like to pursue briefly. You ask to increase what currently is the 30 percent transfer authority between supportive services and nutrition—to up to 75 percent as I recall.

Ms. FISK. In 1990.

Mr. TAUKE. In 1990.

Ms. FISK. Yes.

Mr. TAUKE. Is there any area now that uses the 30 percent authority that is in the law?

Ms. FISK. There is no state that currently does use the full amount of transfer authority. There are numbers that come close, but no one uses the full amount. We want to do this now for a couple of reasons. We think that it is, again, critical that states and Area Agencies have total flexibility to respond to unique local needs. That is responding to unique local needs today, but as you look at our older population and you look at the demographics that we are facing, we think that that ability to transfer funds and respond quickly to unique local needs is going to be even more important as we look at the vast change in numbers of older people. We just want to give as much flexibility as possible in terms of the transfer of those dollars.

Mr. **Tauke**. You have reason to believe that some states would use more authority if they were given it?

Ms. **Fisk**. I believe yes; some have indicated that they would, yes.

Mr. **Tauke**. Why would they be inclined to use the authority?

Ms. **Fisk**. I think we would see a continued emphasis on the very vulnerable old population, the population that may therefore need more supportive and in-home services and the population that would need the home-delivered meal. So, they would be making adjustments in that regard.

I do not think we will see a dramatic immediate change, but I think we, in making this kind of flexibility available, would be positioning us—positioning ourselves, as well as those Area Agencies and state units, to be able to be more responsive as the older population grows.

Mr. **Tauke**. Where would the decision be made, then? At the Area Agency level or at the state level?

Ms. **Fisk**. It has historically been the state level. And, again, I would think states need to have that flexibility to work with Area Agencies to make those adjustments.

Mr. **Tauke**. Some groups have called for the Commissioner to prepare each year a plan of action to outline where the Agency will head in the coming year. Do you have any thoughts about that proposal?

Ms. **Fisk**. Well, I think as a manager of a staff team of, at last count, 173 people, that is an essential component. We have one. We utilize it as the basis for directing our time in headquarters as well as in the regional offices. It certainly is an internal document, not the kind that one would publish. But we have a document of that nature and we use it.

Mr. **Tauke**. So, you would prefer not to have it published, I gather?

Ms. **Fisk**. We are—everything we are doing is in full support of the Older Americans Act. And by looking at the Act, you know what we are doing.

Mr. **Tauke**. How would you react to the proposal—let us be more specific—that you be required to consult with state and Area Agencies on Aging and each year present to Congress a plan of action for your fiscal year?

Ms. **Fisk**. I think the proposal is an unnecessary one. We do consult, in an ongoing way, with states and Area Agencies. In fact, not only do I do that on a personal basis, but all of my 10 regional offices are in constant communication with states and Area Agencies.

I guess my sense is that I do not think that is necessary.

Mr. **Tauke**. How do you respond to the proposal that we lower the age of eligibility to 55 for the services provided under the Older Americans Act?

Ms. **Fisk**. Age of eligibility is an interesting issue. It is one that we continue to have discussions about in the Department and with the Office of Management and Budget. That is a difficult one for me to respond to, today.

Mr. **Tauke**. Why?

Ms. **Fisk**. We have no Administration position that we have agreed upon with regard to that at this point. I guess I would say that for the moment the best course of action is what is in the current law.

Mr. **Tauke**. Thank you.

Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you, Mr. Tauke.

Mr. Solarz.

Mr. **Solarz**. Thank you very much, Mr. Chairman.

I wonder if you could give me some information as to the number of people that are served by various programs that are funded by the Older Americans Act in relationship to the number of senior citizens who are eligible for those services.

For example, with respect to senior centers, do you know how many people or do you have an estimate of how many people use these centers?

Ms. **Fisk**. Well, there are about 30 million older people in this country who are over the age or of the age eligible. And that is 60 and over. Because the program does not have any means testing and does not have any requirements, then you—we say, in truth, that all people over the age of 60 are eligible to benefit, not only from the services, but from the work of states and Area Agencies. About nine million older people are, we feel, are touched by the program.

We keep specific statistics about programs provided under Title III-B, which is the supportive services and by the meals programs.

Mr. **Solarz**. I would like to take it one by one. Let's talk about the senior centers.

Ms. **Fisk**. I do not have those exact figures with me, today. And we would be happy to provide them. Senior centers are particularly difficult for us because in some cases we provide meals there and other cases that we do not. And our data, in an attempt to reduce paperwork and to keep the burden and the administrative costs that we were just talking about low, we have estimates of all the services. And we would be glad to provide them to you.

Mr. **Solarz**. How many Federally funded senior centers are there in the country?

Ms. **Fisk**. I do not know. I could provide that to you.

Mr. **Solarz**. Are there many senior centers that are not Federally funded?

Ms. **Fisk**. Yes.

Mr. **Solarz**. Are more Federally funded or not Federally funded?

Ms. **Fisk**. I do not know. We believe—well, senior centers, of course, exist in every—in every corner of every community. A church can have a senior center and we are delighted that it does, but it may never receive Federal funds.

Mr. **Solarz**. I understand that. I am just trying to get a sense of whether the bulk of the senior centers in the country are Federally funded or——

Ms. **Fisk**. Since we do not know how many there are in total, I would only be guessing.

Mr. **Solarz**. Well, why do you not take a guess.

Ms. **Fisk**. I would prefer not to. I would like to look at our data base and give you the information we have there.

Mr. **Solarz**. And it is your estimate that about nine million senior citizens use senior citizen centers?

Ms. **Fisk**. No. About nine million senior citizens benefit from the programs under the Older Americans Act.

Mr. **Solarz**. How many use senior centers?

Ms. **Fisk**. We would have to check our data base and give you the answer.

Mr. **Solarz**. Do you have a sense that there are more senior citizens that would like to use the centers than there is room for in the existing centers? Obviously, not all of the 30 million are interested in going to centers.

Ms. **Fisk**. Certainly.

Mr. **Solarz**. Have you done any studies to determine whether the need for centers as measured by the desire of people to participate in them is greater than the number that are currently being served?

Ms. **Fisk**. Older people benefit from congregating in a whole variety of places. I think it is true to say that, depending on your personal interest, you may or may not choose a senior center. You may prefer to be in a religious organization. You may prefer to use the library group.

Mr. **Solarz**. I quite agree. My question is: Have you done any studies?

Ms. **Fisk**. No, we have not.

Mr. **Solarz**. In other words, you do not know offhand how many senior citizens actually participate in Federally senior centers, but you say you have the data somewhere back in your office and you can provide that.

Ms. **Fisk**. Yes. And we are not aware of any problems in terms of senior centers. Are you—are you concerned about a problem with the senior centers?

Mr. **Solarz**. Well, what I am concerned about is whether or not we are meeting the need for these centers. I know is that I have 20 or 30 in my district. And I visit them throughout the year, each one a couple of times. And I am tremendously impressed by the role these centers play in the lives of the people who go. I think it is one of the most wonderful things that the Federal Government does in the sense that it provides these people—many of whom would be isolated, friendless, often without the opportunity to get a decent meal, the chance to socialize with their peers, to have a sense of connection to the community, to get a nutritious meal at least once during the day. I think it gives some joy and some meaning to their lives.

I also have the impression that these centers are pretty full.

Ms. **Fisk**. Yes.

Mr. **Solarz**. And I further have the impression, based on lots of calls my office has received over the years, that there are many others who would like to participate in these programs but for whom there is no space available. So, they do not get in.

Now, I recognize we have budget problems and constraints and all that, but I do want to get a sense of whether we are coming anywhere close to meeting the totality of the need or not. And, presumably, you would be the person who would have this information.

Suppose 3 million people are using these senior centers, but there are 6 million people who would like to use them. That would suggest that there would be a need for more centers. Whether we had the money and whether we would determine that that is a prudent expenditure of scarce resources is a separate question. But I want to determine whether there is a need for more centers as measured by the desire of people to participate in them who may not now be able to because there is not room. Can you help me on that?

Ms. **Fisk**. I feel certain that we do not have that level of data that you are looking for. And, in fact, one would be looking for a nationwide survey of each and every older person. I would also say to you that——

Mr. **Solarz**. You do not have to have a survey of 30 million people. There are sample surveys.

Ms. **Fisk**. Certainly.

Mr. **Solarz**. You can do a sample survey and scientifically estimate which would give you the answer to the question.

Ms. **Fisk**. Well, but I think one of the issues that you raise is a very important one and that is the question of Federal priorities. We are eager, as I said in my opening remarks, to see that each and every community is a good place to live and to mature. And the answer does not lie just in the Federal dollars that I have under the Older Americans Act. I am pleased to say that there are many, many other sources of funds that result in good services and good community responses to older people.

The Older Americans Act dollars are a drop in the bucket in comparison to the dollars that are spent in this country to help older people stay in the mainstream of American life.

Mr. **Solarz**. I would like to explore that. Can you get back to us with such information?

Ms. **Fisk**. Whatever we have we will be happy to provide to you.

Mr. **Solarz**. Do you know how many hot meals are served a day in the centers that are Federally funded?

Ms. **Fisk**. We serve, in terms of Federally funded congregate meals, we serve approximately 150 million.

Mr. **Solarz**. Not a day.

Ms. **Fisk**. A year.

Mr. **Solarz**. How many a day?

Ms. **Fisk**. We would have to do the arithmetic.

Mr. **Solarz**. Could you do that?

Ms. **Fisk**. Surely.

Mr. **Solarz**. And do you know whether there are more people that would like to participate in that——

Ms. **Fisk**. I'm sure there are. I'm sure there are.

Mr. **Solarz**. You have no studies, apparently——

Ms. **Fisk**. Each state keeps information. Each Area Agency keeps information on those programs that they manage in terms of waiting lists.

Mr. **Solarz**. Well, do you centralize that information?

Ms. **Fisk**. We collect some of the information, but we try to keep the paperwork burden to a minimum in terms of reporting to us.

Mr. **Solarz**. So, at the moment, you would have no way of knowing whether there are twice or three or four times as many people who would like to participate in the hot lunch programs as actually do participate in them.

Ms. **Fisk**. No. We do not keep that kind of data and we have no way of knowing, since we would not know if we got the total universe included in any waiting list that we had.

Mr. **Solarz**. And what about Meals on Wheels?

Ms. **Fisk**. Meals on Wheels, there are about 75 million meals on wheels—home-delivered meals, not meals on wheels—home-delivered meals provided through our program.

Mr. **Solarz**. Is there some kind of waiting list for that?

Ms. **Fisk**. There are with individual Area Agencies, yes.

Mr. **Solarz**. Once again, I assume you do not know how large the waiting list.

Ms. **Fisk**. We do not ask them to provide that to us.

Mr. **Solarz**. Do you think it might be a useful idea to conduct such studies in order to give us the opportunity to be able to make a judgment about the dimensions of the national need here?

Ms. **Fisk**. I think one can assume that the need outstrips the dollars that we have and we will endeavor to provide the very highest number of meals that we can with the dollars that we have.

Mr. **Solarz**. But do you not think it would be useful to have an idea as to exactly how great the need is?

Ms. **Fisk**. Useful to—for what purpose?

Mr. **Solarz**. For planning, and budget. For establishing budget priorities and determining——

Ms. **Fisk**. I think the usefulness—I think the usefulness would be to the local community because certainly the Federal dollars will never be there to provide the total number of congregate or home-delivered meals.

Mr. **Solarz**. Well, perhaps. But how do we know if we do not know how many actually need the Meals on Wheels program.

Ms. **Fisk**. I think we can make generalizations, given the level of activities of older people, we can make some generalizations about that. But I would say to you, again: There is never going to be enough Federal dollar to put into this program to fully respond——

Mr. **Solarz**. How many did you say are being served now in the Meals on Wheels program?

Ms. **Fisk**. I did not say.

Mr. **Solarz**. How many?

Ms. **Fisk**. I said numbers of meals for home-delivered meals which is different than Meals on Wheels.

Mr. **Solarz**. Yes. What is it here?

Ms. **Fisk**. It's about 75 million.

Mr. **Solarz**. Which is?

Ms. **Fisk**. The home-delivered meals that are provided through our program on an annual basis.

Mr. **Solarz**. How is that different from Meals on Wheels?

Ms. **Fisk**. Meals on Wheels is a nomenclature that is used by a variety of groups throughout this country. We use the general "home-delivered" term so that we do not conflict with the sponsorship that might be public and might be voluntary.

Mr. SOLARZ. Well, for the Meals on Wheels which you say deliver 75 million meals a year; is that correct?

Ms. FISK. We use the term, "congregate meals."

Mr. SOLARZ. Congregate.

Ms. FISK. I am sorry. Home-delivered meals.

Mr. SOLARZ. Home-delivered meals. 75 million a year. Could you give us your estimate as to how many we would have to serve to fully meet the need?

Ms. FISK. No, I could not.

Mr. SOLARZ. Well, a little bit earlier, I thought you said that it was not really necessary to have a study to determine the exact dimensions of the needs because it was possible to generalize it——

Ms. FISK. Well, we could in terms of older individuals who might have limited mobility and inability to cook for themselves. There are certain national statistics that one could apply to the total elderly population to get an estimate.

Mr. SOLARZ. Do you have any estimate as to the total resources necessary to serve all of those senior citizens who could benefit from the variety of services provided in the Older Americans Act?

Ms. FISK. No.

Mr. SOLARZ. You do not.

How much are you recommending we authorize for the Older Americans Act.

Ms. FISK. We are not addressing the budget. The budget is addressed by the Department with a request—that it is a generic line item—with all of the programs under the Office of Human Development Services.

Mr. SOLARZ. Do you know what it comes to for 1988 compared to 1987?

Ms. FISK. There is no number associated with the 1988. It is a generic line item for all of the programs under the Office of Human Development Services. That is to say, programs for all the categories under that and then such sums as are decided upon will be allocated for each program there on in.

Mr. SOLARZ. Would you have a vehement objection to some provision in this law mandating your Agency to conduct some studies in order to determine the degree of need for these programs in relationship to the number being served so that we can simply have some idea of the magnitude of the universe as it would be needed to satisfy the need?

Ms. FISK. I would have no objection to the study, certainly not. I prefer to do studies that I can use for some basis like programmatic changes, however.

Mr. SOLARZ. The questions we have to decide are not just programmatic questions, but also a funding level.

Ms. FISK. Certainly.

Mr. SOLARZ. And I find it very difficult to get a sense of what the appropriate funding levels are if I have no sense of what the total needs are. Now, maybe the total needs are so great that you could not possibly meet it anyway. But even if that is the case, I think we ought to know. And then, conceivably, you could plan incrementally over time to move toward the need. You would not have to do it overnight. But it does seem to me that if you have a program which seems to be working, everybody celebrates it, millions of people benefit from it and others would like to benefit from it and could benefit from it, but we ought to get some sense of how great that need is.

Mr. **Tauke**. Would the gentleman yield?

I think the gentleman makes an interesting point, but I am concerned about the ability of a survey to tell us the information. If I may relate my impressions in my own district.

I talked to those who manage the programs. They indicate that one of their problems is getting senior citizens to participate. There is plenty of capacity, for example, for the congregate meals, but one of the real tasks is to get people who should take advantage of the program getting to the program. So, outreach is a very big part of the effort.

Those who would be surveyed, would say, "No, I'm not interested." When they should be. And I fear—I think for the opposite reason from what you do—I fear the answer would come back that we are doing a better job of providing services than we actually are.

Mr. **Solarz**. Well, the gentleman makes an interesting point. I guess the senior citizens in my district are a somewhat different problem than the ones in yours. In my area, the problem is that they don't have room for those who want to participate. I gather in yours, the problem is there are vacancies, as it were. They could do more, but people aren't coming in.

Let me ask you: Do you have any sense as to the numbers of centers around the country that are serving the maximum number of meals of which they are capable and compared to the number who have the capacity to serve more?

Ms. **Fisk**. I don't have the information with me.

Mr. **Solarz**. Could you provide that?

Ms. **Fisk**. We will look in our data base and see if we have it.

Mr. **Solarz**. Do you also have any information in your data base as to the number of centers that are at capacity in terms of the number of people who are in the centers compared to the number of centers that have excess space or room available that could accommodate more people if they came in?

Ms. **Fisk**. I do not believe we have that, but we will look.

Mr. **Solarz**. Okay. My good friend, I think that is an example of the kind of information that would be useful to have. Until you spoke, I honestly had no idea that one problem might be alerting people to the existence of services because it was——

Mr. **Tauke**. If the gentleman would yield, again. I think part of it, too, is transportation. For example, it may be that the senior citizen center is available, but if somebody can't get to it, obviously, they do not make use of that service.

Mr. **Solarz**. I think, of course, transportation is part of the three services access.

Mr. **Tauke**. Right.

Mr. **Solarz**. Let me say, I think we probably have to make a distinction here between generating a need on the one hand and responding to an existing need on the other. I do not think we can justify spending resources trying to convince people that they ought to come into these centers if they do not want to and they are happy not going into the centers. What concerns me the most are the people who would like to come in, who would benefit from it, but cannot because there is not enough space or they may not have transportation. That is where the real problem is I think there are a lot of senior citizens who would probably not enjoy a senior center. They are more private. They might prefer to read or watch television or hunt or fish or do whatever they do in retirement, take care of the grandchildren, sit in the sun, go to museums.

Mr. **Tauke**. Would the gentleman yield?

I do not know that this is the place to get into a great philosophical discussion, but if we are going to target our resources towards the people who need them the most, my impression is that some of the people who need them the most are the people who are sitting in their homes alone and are afraid to go out or they do not have any contact with the outside world.

The senior citizen who is out there bouncing around trying to get into the senior center usually has enough support and is active enough that they are not suffering from health care needs or nutrition needs that the one who is isolated and sitting home may have.

Mr. **Solarz**. Right. I do not disagree with that all. I think that point makes a lot of sense. I am just saying that there are, a number of senior citizens, many who have no interest in senior centers even if there was room, even if they were offered transportation. They would rather do other things. But there are clearly many who would like to participate if they knew about it or if they could get there. I do not want to make too much of it but it would probably useful for us to have some sense as to the numbers involved. And then we can make some judgment.

Well, finally, are you requesting any specific changes in the law?

Ms. **Fisk**. I have presented a statement to the Committee with a number of suggestions, yes, sir.

Mr. **Solarz**. And that is in the back of your testimony?

Ms. **Fisk**. Excuse me?

Mr. **Solarz**. That is in the back of your testimony?

Ms. **Fisk**. Yes.

Mr. **Solarz**. Thank you very much.

Mr. **Kildee**. Thank you, Mr. Solarz, for a very good line of questioning on that. Let me pick that up a bit.

On the question of unserved needs, just from experience, I have seen that. And it probably varies from one place to another, but, empirically, I have seen unserved needs.

One of the problems is that very often a center is reluctant to advertise outreach because they are already pressed to the limit. I really know that to be the case. So, very often they are very happy to serve, but they look out the window and say, "I wonder if the parking lot is going to fill up even more today because we are really not equipped to serve more than that." And I think that is one reason that many agencies are reluctant to advertise even their existence sometimes because they are already pressed to the limit. I think that is a problem we have to address.

I have often thought at times that we have to give more money for the outreach but, at the same time, I have seen centers that each day have to worry whether they are going to be overwhelmed when more people come in than what they can actually serve. That is a real problem.

Ms. **Fisk**. Certainly, it is a problem. And it is a problem that you see more often in times of fiscal constraint. One of the exciting things about this program and you have all spoken to some success stories that you know of personally. One of the overall huge successes of this program has been the additional dollars that states and Area Agencies have been able to garner for each one dollar, based on their estimates, we are estimating an additional three are drawn out of the community in one way or other, from local tax resources, from private contributions, from profit-making corporations donating a whole range of resources so that this program has been able to generate other resources as Congress hoped it would when the bill was first passed in 1965.

Not the negate the nature of the comment that you make, Mr. Chairman, but I did want to point out how successful the states and Area Agencies have been in this regard.

Mr. **Kildee**. But there are right now places in Michigan where local resources are very difficult to come by. Flint, Michigan, the largest city in my district, right now has plants being closed and people are being laid off. The lay-offs are as high as during the oil embargo. At the same time that they cannot look to any increase—and in some instances see perhaps a decrease in Federal dollars—they are unable, really, to generate local dollars. The local government has fewer dollars coming in and the private sector because the private sector depends upon a healthy economy, too. So, they are really caught in a bind in certain places in the country right now.

I recognize the Federal Government has to be very, very fiscally responsible. One good thing about federal dollars is that the revenue-producing power of the Federal Government is limited by the wisdom and courage of the President and the Congress— the wisdom to cut taxes when possible and the courage to raise them when necessary. And very often, that is not the case in the local level. There are severe restrictions on revenues. So, at least, in good times and bad times, we can use, hopefully, the wisdom and courage of the Federal Government to take care of some of those valleys in the economies of the local areas. There has to be both wisdom and courage.

Mr. **Solarz**. Mr. Chairman?

Mr. **Kildee**. Yes, Mr. Solarz.

Mr. **Solarz**. I had neglected to ask you to elaborate on your comment that the bulk of the services provided the senior citizens around the country come from non-Federally funded programs. And I would appreciate it if you could spell that out a little bit more. What kinds of programs are you talking about? Where does the funding come from?

Ms. **Fisk**. Surely. Nationwide studies indicate—and there have been a number of them done—that 80 percent of the care for older people in this country is provided by family members. And I think each and every one of us have experienced that in our family and our own sense of responsibility for our older loved ones. That is the first and foremost primary place.

And certainly an increased awareness is coming from the private sector. And more and more businesses are beginning to realize that the pressure of caregiving for older loved ones have some of the same results as the pressure, if you will, for child care responsibilities.

We are working with several corporations, now, who are looking at their benefits packages to see what they can do that might be new or different or a variation on a past theme.

Mr. SOLARZ. Let me say I am pleased to hear your figure, because I had long thought that one of the really sad things that has happened in this country has been the decline of the sense of responsibility on the part of younger people taking care of their parents when they get older.

Ms. FISK. No.

Mr. SOLARZ. But I had thought you were referring to these more organized activities like senior centers and the like.

Ms. FISK. Well, certainly that, too. Religious organizations of every shape have taken upon themselves, and we are pleased to see the National Interfaith Coalition on Aging which represents all the groups in an ecumenical council reflects to us the strong emphasis that all the religious denominations are beginning to put on our older population. True, too, from the United Way sector and those kinds of resources.

Mr. SOLARZ. Is it your impression that these religions organizations, the different churches and synagogues and the like have more senior centers that are not Federally funded then there are Federally-funded centers?

Ms. FISK. Yes. I believe that. I would like to check the statistics.

Mr. SOLARZ. Would you provide us some information on that also with——

Ms. FISK. I think this goes back to the very point we were making earlier, that we are looking at some massive changes in the demographics of our country. Each and every one of us know that. Certainly, we are looking at a larger number of older people. Each and every one of us, as we age, will do better. But that does not negate the fact that we do have some tough choices to make here and we have the need to assure that every community in this country sees the responsibility as thoughtfully as you do.

One of the things we have put into our use of Title IV funds this year is to try to help local elected officials understand how important the older person is in terms of decisionmaking at the front lines.

Mr. SOLARZ. If I may make one last suggestion for something you might want to consider in your advocacy role because I gather you take that responsibility seriously.

Ms. FISK. Yes, sir.

Mr. SOLARZ. About 17 years or so ago, when I was in the New York State Legislature I got a postcard from a constituent. We had just established an open enrollment program at the City University of New York in which every high school graduate in the City was guaranteed a place. And he said, "Why do they not have an open enrollment program for senior citizens." This on a little postcard. And I thought it was a great idea.

I went to see the chancellor at the City University and he convened a big meeting with all of these deans and administrators and they all said, "This is not feasible. It will create an administrative nightmare." And he said, "Our responsibility is to serve the community. Let us do it."

And, so, they established an open enrollment program for senior citizens at the City University based on a space-available arrangement whereby if there was room in the course, after all of the undergraduates had signed up, and the senior citizen had the qualifications, they could take the course—not for credit.

And it has been a tremendous success. There are thousands of senior citizens now who take these courses. I remember a year or two after it started, I got a letter from an 84-year old woman living in the Lower East Side, Bertha Farmer, who wrote to tell me that she got an "A" in her course in American History and I think a "B+" in Spanish. And I thought that was just wonderful.

Now, I mention this because it seems to me that your Agency might want to undertake an effort to encourage state universities around the country and community college systems to establish such a program on a space-available basis because I think the life of the mind goes on, you know, long after people retire. And I think there are hundreds of thousands, maybe millions of senior citizens who would really enjoy in their retirement years taking courses on subjects that would be of real interest to them. And, if the classrooms are there and they are not crowding out young people, who need this education to get ahead in their lives, I think it is a way of serving them and bringing the generations together and giving people something challenging to do in their later years. So, I would really encourage you to try to explore this and see if you can encourage colleges to do it.

Ms. **Fisk**. I appreciate that suggestion. I think you would be proud to know that a number of states have followed New York's lead in that that type of program is available in many states. Thank you.

Mr. **Solarz**. Thank you very much.

Mr. **Kildee**. Thank you, Mr. Solarz.

I think this whole question of unserved needs is one that concerns those here at the table here and I am sure it concerns you. I know it does. I recognize, too, that you are getting certain messages from OMB and from the Department through the interworkings of Government. You mentioned the generic appropriations for the Office of Human Development Services and that Aging services are pulled into the generic appropriation.

What bothers me about that generic appropriation is that when you take all the separate components and combine them in that gross figure, which is the generic appropriation, when I add it up, I find that it is $69 million less than the components. So, somewhere along the line, the programs that have been lumped into that generic appropriation are going to lose $69 million. And that is, you know, certainly a matter of concern. We wonder how much will older Americans lose and how much will the other components lose? If the generic appropriation at least took all the components and the gross figure added up the same, we would say, "Well, you know, we are not in too bad of a shape." If it added up to more, as I happen to be a liberal, I would probably be happy.

But when I see it add up to less, I have to ask myself the question: Which programs are going to get less? Right? And that has to concern you, also. It will be your program.

Ms. **Fisk**. Well, I can guarantee you that whatever we get, we will use as efficiently and effectively as possible.

Mr. **Kildee**. We certainly want that. You know, we are working together here for the same people and I recognize your background. Your background is good; your commitment is good. I recognize that. But we really have these hearings to see how we can best serve the people.

You mentioned that the need does outstrip the dollars. And that is a problem. But the problem that bothers me is that when the need outstrips the dollars in the mind of Casper Weinberger, for the most part, he tries to get the dollars to catch up with the need. And he has been rather successful at that. Now, we have slowed down a bit in the last year and a half, but he has been rather successful. He looks at the need and then he convinces, you know, the President that "Here is the need. Let us catch the dollars up to the need."

Why is it that he is always successful—that he tends to be much more successful than most of the other agencies—and not just yours—at getting the dollars to catch up with the needs?

Ms. **Fisk**. I am not sure that I can respond to that. I would say that defense is certainly an activity that we must undertake collectively and it is not an activity that each and every one of us can undertake alone, and, therefore, our combined strength is exceedingly important to us as a nation; whereas our combined response to our older population is just as important, but I say to you again that this is not an answer that is going to come just from my budget. It is the answer that is going to come from each and every community looking at its older population, responding today and planning for the future.

We have put together a little check list that we will be disseminating in May, because, of course, as you know, May is Older Americans' Month. This year's theme is: "Make your community work for older people." And I will leave copies of the check list for you and for all members of the committee. I think Secretary Bowen is deeply committed to the needs of older people. His work in the area of catastrophic illness has demonstrated that. I think he is indeed a strong advocate for older people as well as for all the vulnerable people our Department has to speak on behalf of. I think he is just as strong an advocate as others you might mention. I am proud to work for him.

Mr. **Kildee**. I think he is one of the better people in the Cabinet. I have serious problems with many members in the Cabinet, but I think he is one of the better members. I guess the bottom line is successful advocacy. And Casper Weinberger has a tremendous record of success.

If the carelessness in spending the money that I think takes place in the Pentagon took place in your shop, they would really have the auditors in there. I always carry around a little packet of $21,000 worth of spare parts here that I could have bought for 31 cents. And if you were to do that in your shop, you would really be in trouble.

My two boys are Boy Scouts. Last Christmas time I was helping my two boys sell Christmas trees. I saw this limousine pull up there. It was so long, it had to back up to go around the corner—a little exaggeration—but out came Cap Weinberger to buy a Christmas tree, and I was going to say, "Capp, we've got a tree for you for $900." But I did not. I sold it to him for $30. Of course, it was a $15 tree. [Laughter.]

It was not, really. No. I gave him the right price. But my point is that he has been a good advocate, a successful advocate. I really think that we need advocacy for these programs. I am an advocate as Chairman of this subcommittee. But I am not a blind advocate. I am out there in the field and I see these programs, and I know you see them, too. But I have been in places where there is, perhaps, an eye to the window to wonder whether more people are going to come in than can be served and there develops that built-in reluctance, perhaps, to outreach and advertise the existence of the program.

I do think that we have to look at the needs of this country and the human needs are very, very important. You and I and most people in this room or many people in this room—I do not know the background of everyone—but you and I will do pretty well no matter what Government does. We will do well. But there are some people who really depend so much on a sensitive Government. Our old people are certainly a group that depend very much on a sensitive Government. And for that reason, we have these hearings: to see how we can translate our concern into some programs that really will serve these people.

I have one other question and I do appreciate your cooperation with the committee. One issue that is receiving an increasing amount of attention is the apparent decline in minority participation in the Older Americans Act programs. And the fiscal year 1987 appropriation required a report on minority participation under the Older Americans Act prior to the beginning of the fiscal year 1988 budget process. Could you tell us the status of that report?

Ms. Fisk. The report has gone this morning back to the Department for review. And we were tardy in our submission. We think you will find it a very thoughtful document that we have labored over long and hard. We looked very closely at minority and low-income participation and we went back to the individual state through our regional offices to re-evaluate the data.

In past years, prior to the—prior to 1980, basically, most of the data that we were getting was estimates. As we look now at comparing data from the 1970's to data of the early 1980's, we do see some differences. But we have satisfied ourselves that those differences result in large measure due to reporting procedures. And that the data is more consistent in the 1980 period and shows a slight decline, but basically 1 percentage for minorities as well as for the low-income. I think you will find it a thoughtful, certainly a lengthy report, but we think—included in there also is documentation of the major efforts that states and Area Agencies continue to make to assure that services are aimed at the most vulnerable, including the low-income and minority. That document should be reaching you I understand before the end of the month.

Mr. **Kildee.** Thank you very much.

Mr. Tauke?

Mr. **Tauke.** Thank you, Mr. Chairman.

I cannot help but observe that if we would go back and look at the 1984 budget adopted by Congress and look at what we projected would be spent by the Department of Defense and the Department of Health and Human Services during the current fiscal year, Secretary Bowen has been much more successful in maintaining his level of funding than Secretary Weinberger has been in maintaining his level of funding.

Mr. **Kildee.** That was 1984; was it not?

Mr. **Tauke.** Yes, since 1984. If I were the Commissioner, I think I would ask why it is that the majority of the Members of the House and Senate decide to respond more favorably to the pleas of one segment of the Government than pleas of another. I am not sure that it is her responsibility, I guess, to answer that question.

Let me just explore another area. And that is cost sharing or fees for service. One of the proposals that has been offered to attempt to spread the availability of services is to have some fees for those who can afford them or some kind of cost-sharing. Do you have any observations you would care to offer about that concept?

Ms. **Fisk.** Congress has been fairly adamant in the past that it is very concerned that this program not be means tested and I think in 1984, most recently removed language that focused or included the opportunity to solicit charges because we have all felt—all of us, the Administration as well as Legislative Branch, that this program does have a special role to play in that it serves as the advocacy base as well as the service base for all older people.

Having said that, however, we raise a very critical issue—critical, today—which the Department has yet to reach resolution on. We continue to have discussions in-house and that item is not addressed in our package at this point.

We have done very well in terms of stimulating contributions, voluntary contributions in accordance with the law. I am impressed with that. And I am impressed with the sensitivity with which states and Area Agencies have addressed the issue of contributions.

I do share, however, the concern that we also have about people who continue to see this is a totally free program and do not make any contributions.

In the time limitations, certainly that is an issue that has to be addressed. And we have argued both sides of it within the Department and have been discussing this for several months. I await to hear what final decisions will be made with regard to that issue.

Mr. **Tauke.** Do you have any indication when you might be able to make a recommendation to us on that issue?

Ms. **Fisk.** I would say we will have a bill to you shortly and if a decision is made on that issue, it will be contained therein.

Mr. **Tauke.** Okay. Thank you very much, Commissioner.

Ms. **Fisk.** Thank you.

Mr. **Kildee.** I appreciate very much your testimony today. We have asked you some tough questions, but you responded to the questions, although maybe not to our total satisfaction. We might want better answers. But I do know this: that your own reputation is excellent. You have a reputation of sensitivity and concern. And, for that reason, I certainly look forward to working with you as we go through the reauthorization of this bill.

Ms. FISK. Thank you. I really appreciate those kind remarks and look forward to working with the entire committee. I am very impressed with the nature of your discussion and your concern here. And I think that speaks well for your advocacy, for your wisdom and for your courage on behalf of older people. Thank you very much.

Mr. KILDEE. Thank you very much, Commissioner.

Our next witness is Elaine M. Brody, Associate Director of Research, Philadelphia Geriatric Center, Clinical Professor of Psychiatry of Medical College of Pennsylvania and former president of the Gerontological Society of America in Philadelphia.

Good morning.

STATEMENT OF ELAINE M. BRODY, ASSOCIATE DIRECTOR OF RESEARCH AT THE PHILADELPHIA GERIATRIC CENTER, CLINICAL PROFESSOR OF PSYCHIATRY AT THE MEDICAL COLLEGE OF PENNSYLVANIA

Ms. BRODY. Good morning. Mr. Chairman, I appreciate the opportunity to testify this morning on the proposed amendments to the Older Americans Act. I have worked at the Philadelphia Geriatric Center for about 32 years. The Philadelphia Geriatric Center is a non-profit organization that cares for about 1200 older people on its campus. We have nursing homes, high-rise apartment buildings with services for the elderly, small scale housing and a fully accredited geriatric hospital. We also serve thousands of older people who live in their own homes or the homes of their relatives. And we serve those by means of day care, a consultation and diagnostic center, in-home services, counselling for caregivers, and satellite medical clinics scattered throughout the city. Our Gerontological Research Institute carries out social, behavioral, and bio-medical research studies and demonstrations.

I tell you that in order to identify the PGC as having had many years of extensive experience in developing and delivering in-home services such as those in the proposed amendments to the Older Americans Act.

I first testified about the Older Americans Act in 1972 before this very committee and in joint testimony with Dr. Stanley Brody of the University of Pennsylvania. At that time, we commended the bill for the priority it gave to those elderly in greatest need and stated that the target population for services should be the high risk groups of elderly. That priority is even more urgent and better defined today than it was 15 years ago.

In those 15 years, our PGC research staff has carried out large studies of family caregiving to the disabled elderly and our service operation has devoted major resources to helping such caregivers to the fullest possible extent. We have struggled against the odds of meager and uneven funding. Our research studies and those of researchers elsewhere in the United States are unanimous in confirming the reliability of the modern family and the strenuous effort it makes to care for the disabled elderly. There has been no decline in the family responsibility.

However, the task faced by caregiving families nowadays is much greater than used to be the case because of the large proportion of frail elderly in our population, the decreased number of adult children to share their care and the increase in chronic ailments that result in prolonged dependency.

We have developed new information since 1972, of course. We now know that about half of family caregivers suffer moderate to severe stress effects, primarily in the realm of negative mental health symptoms, but also negative effects on their physical health and economic strain on families. We know what produces such strain—the provision of "heavy care" to extremely disabled older people with multiple deficits in their ability to care for themselves, for example, those who may be incontinent or have mental conditions such as Alzheimer's disease, or who have been receiving care for long periods of time from overburdened family members, who most often are in late middle age and are the grandparent generation.

One of our studies—financed by the National Institute of Mental Health—found that significant portions of caregiving family members find it necessary to quit their jobs or cut back on their work hours in order to care for disabled family members. And these findings have been confirmed on a broader scale by the 1982 Long Term Care Survey sponsored by the Department of Health and Human Services. Both studies—ours and the Long Term Care Survey—also found that more than 85 percent of the care received by older people is provided by the family. In fact, only 4 percent of older people who need the most extreme form of care—help with activities of daily living—receive that help or receive any help from the formal system of government and agencies.

Moreover, only a tiny fraction of the care is paid for by government or private agencies. The 1984 National Health Interview Survey found that only 1 percent of older people received homemaker service, 2 percent received home-delivered meals, 3 percent received visiting nurse service, and 2 percent received help from home health aides. So few were day care participants that reliable estimates could not be made.

In view of the earlier discussion, I might mention that that survey found that 15 percent of older Americans attended a senior citizens center, although, of course, there is no information available to me about the sponsorship, whether it was Federal or not. And about 8 percent of those who attended the senior citizens centers take their meals there.

The cost of the mental and physical health care for caregivers who suffer stress has not been calculated. Nor do we know the opportunity costs for those who are deterred from entering the labor force or who are compelled to leave it, for those who work fewer hours or with anxiety about what is going on at home or who are finally compelled to place their older relatives in nursing homes after years of arduous and exhausting care. Taken together, the health care costs and opportunity costs may be of an enormous significance to our nation as well as to the individual concerned. And that has not been costed out.

But in that context, the need for in-home services such as those described in the proposed amendments cannot be over stated. Let me give you just one example. My colleague, Dr. Powell Lawton and Ms. Avalie Saperstein at the Philadelphia Geriatric Center, my colleagues and I are just completing a large demonstration research respite care project financed by the John A. Hartford Foundation of New York and the Glenmede Trust. We offered respite service to caregivers whose elderly family members have Alzheimer's disease or a related disorder, an ailment that places extraordinarily heavy demands on caregivers. Those caregivers were free to choose the form of respite that would be most help to them—day care, temporary placement in our nursing home or hospital, or in-home services. Overwhelmingly, in more than three-quarters of the case served, in-home respite was the plan they chose. And that, I submit is a clear demonstration of the pervasiveness of the need for that kind of service. I might say that the families were very modest in the demands that they made and were more than willing to pay what they could afford to the fullest possible extent and we supplemented when they could not afford it. And that finding about the "modest demands" that families make for services simply replicate what has been found in other studies across the nation, including one in Mr. Solarz' constituency in New York by the Community Service Society.

Now, information about the pressing need for in-home services has been available for many years. As indicated by the figures I cited, however, public policy has not really put knowledge to work on behalf of millions of citizens who need it. The Title III network has made major contributions—and I emphasize that—that has helped millions of Americans. It has identified and emphasized the problems faced by our elderly and their families and it has developed methods of dealing with those problems. And the proposed amendments have our strong support.

The provisions will continue in that vein by focusing attention on the need for in-home services. Of course, as the committee recognizes, I am sure, $25 million allocated to the at-risk population of 5 million disabled older people certainly will not go the whole distance in actually serving older people and their families.

The ultimate goal in my view is for the Area Agencies to play a coordinating, consolidating, monitoring role to assure continuity of care rather than functioning as direct service organizations. I was very pleased to hear Commissioner Fisk this morning talking about that coordinating/monitoring role that she sees for the Title III agencies.

In that capacity, they could assure maximum utilization not only of Title III funds, but also of those provided by Medicare, Medicaid, Title XX, Veteran's Administration Benefits, Food Stamps, Mental Health and the many other public and private services. I feel that ultimately the role that the Title III agencies should play would be to monitor and coordinate and identify the need rather than to be in competition with the existing service agency.

This was the AAA role that Dr. Brody and I suggested in our 1972 testimony and it has been elaborated and spelled out very fully by Dr. Robert Binstock. That paper is in press and he probably would be willing to give it to the committee, an advance copy, if it wanted it.

What we really need is to protect disabled older people and their families. We need Federally-financed long-term care insurance with services organized so as to provide continuity of care as people's needs change over time and to avoid fragmentation and separate delivery systems on the basis of selected types of services.

I do not agree that enough dollars will never be available to take care of our most needy citizens. Dr. Brody, in a seminal paper has pointed out methods of dealing with this issue and that it is not a bottomless pit to provide long-term care insurance to the most severely disabled of our American citizens so that I think that this absolutely can be done.

To return to the AAA, I underlined that they could be a highly visible presence in each community which those in need could turn for appropriate referrals to the multitude of diverse services now available, though in short supply, and for linkages to and monitoring of those services.

I emphasize that because there now is a bewildering array of services that are available. And it is very hard for older people and their families to sort out that array of services and to know where to turn, how to access those services, in addition to the problem that you pointed out, Mr. Tauke, to the effect that some people need the service but may not be able to use it, either because of misunderstanding or because of some other kind of problem. And that, too, needs to be addressed.

I also would add a comment to the effect that I do believe that it would be extremely valuable for a role of the Administration on Aging to identify the unmet needs by tracking the requests in the various communities for services that people want but that are not available to them because they are in short supply. Needs assessment is a terribly difficult thing to do. It is possible to identify the numbers of people who have disabilities, but there are so many factors determining usage of service, that that is a very tricky business, but, certainly, tracking the number of requests for services and identifying people who want the services and cannot get them would be a very valuable kind of thing.

On behalf of the Philadelphia Geriatric Center and of older people and their caregiving families, I again thank you for the privilege of presenting these views.

[The prepared statement of Elaine M. Brody follows:]

PREPARED STATEMENT OF ELAINE M. BRODY, PHILADELPHIA GERIATRIC CENTER

My name is Elaine Brody. I am Associate Director of Research at the Philadelphia Geriatric Center (PGC), Clinical Professor of Psychiatry at the Medical College of Pennsylvania, and a past President of the Gerontological Society of America. The Philadelphia Geriatric Center is a non-profit organization that cares for more than 1200 older people on its campus in its nursing homes, high-rise apartment buildings with services, small scale housing, and a fully accredited geriatric hospital. We also serve thousands of older people living in their own homes or with relatives by means of day care, a consultation and diagnostic center, in-home services, a program of counselling for caregivers, and satellite medical clinics. Our Gerontological Research Institute carries out social, behavioral, and biomedical research studies and demonstrations.

I first testified about the Older Americans Act in 1972 before this Committee in joint testimony with Dr. Stanley Brody of the University of Pennsylvania. At that time we commended the Bill for the priority it gave to those elderly in greatest need and stated that the target population for services should be the high risk groups of elderly. That priority is even more urgent and better defined today than it was then.

In the 15 years since 1972 our PGC research staff has carried out large studies of family caregiving to the disabled elderly and our service operation has devoted major resources to helping such caregivers to the fullest possible extent. We have struggled against the odds of meager and uneven funding. Our research findings and those of researchers elsewhere are unanimous in confirming the reliability of the modern family and the strenuous effort it makes to care for the disabled elderly. However, the task faced by caregiving families nowadays is much greater than used to be the case because of the larger proportion of frail elderly in our population, the decreased number of adult children to share their care, and the increase in chronic ailments that result in prolonged dependency.

New information has been developed since 1972, of course. We now know that about half of family caregivers suffer moderate to severe stress effects, primarily in the realm of negative mental health symptoms, but also negative effects on physical health and economic strain. We now have knowledge of the factors that produce such strains -- the provision of "heavy care" to older people with multiple deficits in their ability to care for themselves, for example, or care of those who are incontinent or have mental conditions such as Alzheimer's disease, or who have been receiving care for long periods of time from overburdened family members (who are most often in late middle age and are the grandparent generation).

One of our studies (financed by the National Institute of Mental Health) found that significant proportions of caregiving family members find it necessary to quit their jobs or cut back on their work hours. These findings have been confirmed by the 1982 LTC Survey sponsored by the Department of Health and Human Services. Both studies, ours and the LTC Survey, also found that more than 85% of the care is provided by the family. In fact only 4% of older people who need the most extreme form of care -- help with activities of daily living (ADL) -- receive help from the formal system of government and agencies. Moreover, only a tiny fraction of the care is paid for by government or private agencies. The National Health Interview Survey found that only 1% of older people received homemaker service, 2% received home-delivered meals, 3% received visiting nurse service, and 2% received help from home health aides. So few were day care participants that reliable estimates could not be made.

The cost of mental and physical health care for caregivers who suffer stress effects has not been calculated, nor do we know the opportunity costs for those who are deterred from entering the labor force or who leave it, who work fewer hours or with anxiety about what is going on at home, or who are finally compelled to place their older relatives in nursing homes after years of arduous and exhausting care. Taken together, those health care costs and opportunity costs are of enormous significance to our Nation as well as to the individuals concerned.

In that context, the need for in-home services such as those described in the proposed amendments to the Older Americans Act cannot be over-stated. Let me give you just one example. My colleagues (Dr. M. Powell Lawton and Ms. Avalie Saperstein) and I are just completing a large demonstration/research respite care project at the PGC financed by the John A. Hartford Foundation and the Glenmede Trust. We offered respite service to caregivers whose elderly family members have Alzheimer's disease or a related disorder, an ailment that places extraordinarily heavy demands on caregivers. The caregivers were free to choose the form of respite that would be most helpful to them -- day care, temporary placement in our nursing home or hospital, or in-home services. Overwhelmingly, in more than three-quarters of the cases served, in-home respite was the plan they chose, in a clear demonstration of the pervasiveness of the need for that kind of service. I hasten to add that day care and nursing home respite are also important as are other forms of in-home services. The various types of services meet different needs.

Information about the pressing need for in-home services has been available for many years. As indicated by the figures I cited, however, public policy has not put that knowledge to work on behalf of the millions of citizens who need it. The Title III Network has made major contributions. It has helped millions of elderly Americans. It has identified and emphasized the problems faced by our elderly and their families. And it has developed methods of dealing with those problems. The proposed amendments have our strong support. The provisions will continue in that vein by focusing attention on the need for in-home services. Of course, 25 million dollars allocated to the at risk population of 5 million disabled older people certainly will not go the whole distance in actually serving older people and their families.

The ultimate goal, in my view, is for the Area Agencies to play a coordinating, consolidating, monitoring role to assure continuity of care, rather than functioning as direct service organizations. In such a capacity they could assure maximum utilization of not only Title III, AoA funds, but also those of Medicare, Medicaid, Title 20, VA benefits, Food Stamps, Mental Health and the many other public and private services. This is the AAA role suggested in our 1972 testimony and that has been elaborated and spelled out by Dr. Robert Binstock. What is needed to really protect disabled older people and their families is federally financed long term care insurance with services organized so as to provide continuity of care as people's needs change over time, avoiding fragmentation in separate delivery systems on the basis of selected types of services. The AAAs could be a highly visible presence in each community to which those in need could turn for appropriate referrals to the multitude of diverse services now available (though in short supply) and for linkages to and monitoring of those services.

On behalf of the Philadelphia Geriatric Center and of older people and their caregiving families, I thank you for the privilege of presenting these views.

Mr. **Kildee**. Thank you very much, Ms. Brody for your testimony. As you are aware, the reauthorization bill that I introduced proposes a new authorization for in-home services for the frail elderly. What kind of in-home services are most critically needed for frail older persons living in the community?

Ms. **Brody**. Well, there are several different groups of older people, sir. Certainly, for those who do not have family available, many services are needed depending on the level of dependency of the older person.

Older people, in general, with or without families, the most severely disabled are the ones who need two general groups of services. One is referred to in the field as activities of daily living, ADL. And that subsumes all of the personal care kind of services that people need; specifically, being taken to the toilet, transferring in and out of bed, dressing, feeding, bathing. That kind of intense personal care.

Another level of care are the instrumental activities of daily living. And those people are not quite as severely disabled and those include housekeeping chores, transportation, supervision of medication, laundry. That kind of thing. So that the need of older people really depends not only on their own level of disability, but on the resources available to them in the form of family.

To be more specifically responsive to your question, I think we certainly need homemakers' services, some in-home nursing care. The families are desperately in need of respite care, which is simply some form of relief from the ongoing, unrelenting tasks of caring for older people. We have come across families in our research who haven't been out of the house in two years because there is nobody to take over the care of the older person while they are gone.

And while in-home respite is tremendously important, it is also important to have other forms of respite available. A family may be taking care of an older person, but there is a severe illness of the caregiver or of her husband, and they need temporary placement in either a nursing home or a hospital before they can take the older person back.

Daycare is another one of those services: some place for the older person to be during the day to give the caregiver a break, once in a while, or on a consistent basis, if they are working or whatever. But those kinds of services have no consistent funding. And they are uneven regionally across the country. Most of them are funded either by waivers or by foundation grants which then end and there is no consistent funding to pick up the slack. And that is happening to us right now. We have served hundreds of people in our respite program, but the demonstration research funds have run out and we do not have funding to replace that for the needy people.

Mr. **Kildee**. Speaking of the respite care for the caregiving family member, is it not the case that very often the caring family members, themselves, are not all that young? You may have an 85-year old parent, and very often the family member who is providing care in the home is not, robust or in the best health.

Ms. **Brody**. That is exactly right. Because if the impaired person has a spouse, that spouse is the first-line caregiver. And, as might be expected, the spouse, himself, or herself, would be in old age, be somewhat frail, have some of the chronic ailments that are related to age and so on. But most of the very frail older people are the very old people. They are in advanced old age, 85 or over, and certainly 75 or older. And most of that population is widowed. Therefore, most of the responsibility for help to these very frail old people in advanced old age falls on adult daughters, if there is a daughter. Daughters outnumber sons about three to one in taking care of frail older people. And adult daughters predominate in taking care of the very frail old.

Now, those adult daughters most often are in their 50's, but a full one-third of them are either over 60 or under 40, so that the caregivers are at many different stages and ages and each has its own problems. It is obvious that a young woman under 40 with school-aged children who is taking care of an older person has a set of problems that are rather different from those of a very frail older spouse.

Mr. **Kildee**. Mr. Tauke.

Mr. **Tauke**. I do not really have any questions to ask you, but I do thank you for excellent testimony. The problem which you highlight is one that is so evident to us as we deal with senior citizens and those who are attempting to assist senior citizens. It is a problem that keeps coming up over and over and over, again. And I hope that in the course of our reauthorization that we will be able to provide some assistance to begin to deal with the problem.

You indicated, as I did at our last hearing, that 25 million is a very small amount to deal with this problem. With that kind of money, what is it that we can best do?

Ms. **Brody**. Well, I really do believe, sir, that there ought to be over time a transition from the Administration on Aging being in the direct service business to being in the monitoring, coordinating, a visible information referral kind of role. I think every little bit helps. And I am very much in favor of the money being allocated to in-home services because we do not have nearly enough now, but the ideal solution, the long-range goal, if we can all dream—and I think the fulfillment of those dreams is within the realm of possibility, would be to have full coverage and for Administration on Aging then—those AAA agencies then to play that very important role in the community of visible to older people. They know where they can go for help. Their families know where they can go. They can get referrals to the agencies, the quality could be monitored and so on.

Mr. **Tauke**. Thank you.

Ms. **Brody**. You have a lot of competition in the service business.

Mr. **Kildee**. I had a number of questions to ask, but you covered them so well in your testimony quite well. One of the good parts about the job which I hold and Mr. Tauke holds, is the fact that we are able to become educated by the very top people in the field. And you certainly have done that well this morning. We appreciate your testimony. I would like to be able to call upon you, again, between now and the time we finally reauthorize this bill so we could have the benefit of your knowledge again in this.

Ms. **Brody**. Thank you. It would be a privilege to respond to that request. And, again, I thank you on behalf of older people, not only because I am committed to their well being, but I soon will be entering that category, myself.

Mr. **Kildee**. Thank you very much for your testimony this morning.

Next, we have one of our colleagues before us, the Honorable Ron Wyden, from the U.S. House of Representatives.

Ron, would you step forward here? Your record of involvement in this area was well known before you joined us in Congress a few years ago and we appreciate your present endeavors and your past background in this.

Go ahead, you may begin when you wish.

STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. **Wyden**. Thank you very much, Mr. Chairman. It is a pleasure to be here before you and my good friend, Tom Tauke. The three of us have had a chance to work together on a number of issues. I just appreciate all the good work that you are doing in this subcommittee. There are so many vulnerable older people and with the tough economic circumstances we are in, you job is immeasurably more difficult. I appreciate the commitment you and Congressman Tauke have given to try to help stretch our resources and do the best we possibly can for vulnerable older people with the Older Americans Act.

Mr. Chairman, I am not going to read my statement and with your consent, if it could be put in the record.

Mr. **Kildee**. Without objection, the entire testimony will be included in the record.

[The prepared statement of Hon. Ron Wyden follows:]

PREPARED STATEMENT OF HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. Chairman, I want to thank you for having me here today.

Today, the Subcommittee is considering vital programs funded under the Older Americans Act. Before coming to Congress, I was the executive director of the Oregon Grey Panthers. In that role, I saw first hand the excellent projects and results that the Older Americans Act has made possible. From Meals-on-Wheels to legal services to advocacy, the Older Americans Act serves seniors superbly.

In the last 5 years, $30 billion has been cut from Medicare and Medicaid programs. At the same time, the older population has grown and, with it, their needs for health care services - particularly care in the home. It's time to look for fresh ideas to strengthen the Older Americans Act. H.R. 907, the Volunteer Service Promotion Act, presents a new approach to serving the long term care needs of America's seniors. By utilizing volunteers, it permits our country to increase the availability of critically needed health care services.

The bill, which I introduced with my colleagues Pat Williams and Bill Goodling, will instruct the Commissioner on Aging to establish demonstration projects to promote volunteer exchanges. Under our bill, volunteers in selected programs would be able to earn credits for their service. People over 60 could volunteer in exchange for a credit when they serve any other person over 60 or a low-income child. These credits could be accumulated and those earning them would have the option to use them for similar services for themselves and their families when needed.

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No new Federal funds are needed to implement this bill and no new Federal bureaucracies are created. The bill requires the Administration on Aging to use existing funds to establish 5 to 15 volunteer service credit programs for elderly people under the Older Americans Act. Those programs would be operated by the State offices on aging.

A particularly exciting aspect of the bill is that it would promote closer ties between the generations by allowing elderly people to earn credits by serving low-income children. For example, many communities are in desperate need of child care or tutors for disadvantaged youths. The elderly are in a unique position to be able to give those services.

Finally, the bill allows volunteers to donate their credits to others who are in greater need of the services they have earned. This will encourage capable individuals to volunteer in order that a family member or friend - as well as the person directly receiving their services - could benefit .

In my home state of Oregon, the Senior Services Division of the Human Resources Department is preparing contracts with community groups to implement service credits this spring. Under Oregon's plan, the state will provide $3000 of computer hardware to senior centers. The centers will recruit, train and supervise volunteers, track credits and insure the programs - all free of charge to the state. Tne Volunteer Partnerships for Independence program will be up and running in a matter of weeks serving seniors in Southeast Portland, Albany, Oregon and, perhaps, Woodburn, Oregon. The willingness of the state and the senior centers to cooperate on these creative ventures gives a good indication of how successful we can be in establishing volunteer networks nation-wide.

Many communities need our help in getting these unique programs going. Without creating any new spending, we can give elderly service organizations an opportunity to get increasingly necessary long term health care services to seniors in their homes and at local community centers. At a time when we are thinking of expanding hospital stays under Medicare, we must also think about making basic custodial care and preventive health services more accessible. Tapping into the extensive volunteer network that already exists is a must for the Area Agencies on Aging and other Older Americans Act programs.

Mr. Chairman, volunteers - specifically elderly volunteers - are a wellspring of valuable service for our country. I believe H.R. 907 gives us the opportunity to test a promising idea for strengthening that great resource.

I appreciate your having me testify today. I'd be happy to take your questions.

Mr. Wyden. Thank you, Mr. Chairman.

I wonder if I might make a few remarks about a concept that I am very excited about and think holds a good deal of promise. I think the Members on both sides of the aisle want to attack this long-term care issue in this Congress.

After the President made his proposal for catastrophic care, which certainly covers some of the gaps, particularly for older people who need a great deal of hospital stay coverage. Many Members on both sides of the aisle began to shift their attention to trying to deal with these crushing long-term care bills: these bills that are not covered by Medicare and so many older people are not low income enough for Medicaid. But they still do not have the resources to pay for it themselves and find that Medicare does not cover it so they go without.

I would like to see Congress in this session try to make a beginning to a long-term care policy and try to find the resources to do it. If you say that there is that bipartisan interest—and I think it is very strong, the home care looks like one of the best places to start. Older people very much want to have new alternatives in the home care area. I think there is a lot of evidence that would indicate home care is more cost effective than the alternatives, particularly, the institutional care.

So, the question I faced at the beginning of this session is: What might we be able to do to try to get more help to older people in their home during these tough times. And in the course of my contacting people in the geriatric field around the country and I have tried to keep my contacts up in this area, I learned about the service credit concept that I would like to discuss today.

The notion of service credits is an awful lot, Mr. Chairman, like blood banking or bartering or something of that nature. The notion would be that if an older person was willing to volunteer and help another older person in their home or a variety of other settings, the older person who volunteered would, in effect, earn what would be called a service credit. A specific credit that could then be applied if they or a family member needed help in the home later on down the road.

One of the things I liked about it was we would not have to create any new Federal agencies or new bureaucracies. I have been in contact with people in the Area Agencies on Aging and the senior centers and I think the way it would probably work is that the senior citizen volunteered, say, in Cedar Rapids, to help out another older person. They would probably keep the record at the Cedar Rapids Senior Citizens Center, the Portland Senior Center or they could send the record to the Area Agency on Aging for Cedar Rapids. So, it would not go any further than those two spots: the local place where the contact would be made such as a senior center and the Area Agency on Aging.

I have never seen this as something that would create binding legal rights. We do not want people going to court to claim their service credit or anything of that nature. I think what we would like to do, under this kind of concept, is try to give new prestige and new recognition to volunteers and try to get some more visibility for this cause of serving older people in the home.

I think we all know that a lot of this kind of work already gets done. No one is suggesting suddenly inventing volunteerism in the United States in 1987.

My thought is, with something like this we might be able to generate some new volunteers and some new, in effect, service hours or assistance to older people in this particular setting. Now, I am also not saying that we should suddenly go out and say automatically, "This is the greatest thing since night baseball and the answer to everything." But I have proposed in my legislation which is a bipartisan bill co-sponsored by two of our friends on the Committee, Mr. Goodling and Mr. Williams, is that under the Older Americans Act, we make available some funds to do some more demonstration projects in order to press this out a little bit more extensively.

Some of the states are trying to get this off the ground. It has been tried in several jurisdictions. Washington, DC, is now getting theirs off the ground. My home state of Oregon, last Monday, I was with the senior citizens at home and they have been starting a project with $3,000 from the State Aging Office, basically to help deal with the process of keeping the records and what we are proposing—Mr. Goodling and Mr. Williams and myself—is that the Administration on Aging set up something like 5 to 15 volunteer service credit programs for older people under the statute, and test it out over the life of the reauthorization and then we could make an evaluation at that point.

I think it is something that would have a lot of promise. In talking with senior program administrators and senior citizen volunteers around the country, and I think the last point that I would make is we cannot afford not to try this kind of thing. I am not saying that this is going to be the magical answer. We are, in effect, trying to do more and stretch our resources in order to get into this long-term care issue at a time when there are less resources because of these huge Federal deficits. I do not think we can afford not to try to look at these kind of innovative, innovative approaches. I think it will help us generate some new volunteers. It has been met with considerable enthusiasm among senior citizens' groups and their advocates. I would like very much to work with you and Congressman Tauke and the others on the committee to see if there is a way we can promote this and encourage some further testing.

Mr. **Kildee**. Thank you, Ron. There is a program in Missouri at the present time and one also in Florida. Would your program operate somewhat along those lines or do you have some changes you would recommend?

Mr. **Wyden**. No. Those are very similar, Mr. Chairman. I think the Florida program has received enabling legislation—state-enabling legislation. I do not think it is actually off the ground.

Our check has indicated that of the four states—Louisiana, Missouri, Florida and the District of Columbia, the one that is the furthest along is the District of Clumbia. It has actually been funded and started operating. I think we gave to the subcommittee a "New York Times" article on that program, February 23rd, 1987, which I felt was very encouraging. It is a program run from the Greater Southeast Community Center for the Aging in a low income community, Anacostia, over by the Maryland border. And I think they are very encouraged by the progress.

Mr. **Kildee**. One of our constant problems here is that if we add new programs to a certain title, we worry about dilution of the present programs. What would you think of the concept of maybe adding a subtitle to Title IV as an authorization, and then giving to Appropriations to see whether they then could give some appropriation for that subtitle. In that fashion, we would not then be diluting the other programs in Title IV. Would you feel that might be an approach?

Mr. **Wyden**. I guess my only concern about that, Mr. Chairman, is I know the challenge of the Appropriations Committee well. I fear it could possibly fall to the wayside.

If there would be any way, all we want to do is test it. We tried the idea of 5 to 15 projects out on the aging advocates and others. Nothing is fixed in stone on this in terms of the amount or the number of projects. If there would be a way that you could put this in the authorization, I think that would be the way to make sure that it actually gets a test. I know your bill is going to get strong bi-partisan support as it has in the past. I fear that it might get lost unless we can get it in the bill. If you could, either from the demonstration project account or somewhere else, manage a few tests I think would be a very productive effort at this point.

Mr. **Kildee**. Thank you.

Mr. Tauke?

Mr. **Tauke**. Thank you, Mr. Chairman, and welcome Congressman Wyden. It is good to have you here. As you may know, the Congressional Clearinghouse on the Future has been doing some work on this idea that you have introduced along with our colleagues, Pat Williams and Bill Goodling.

According to the information that the Congressional Clearinghouse has put together, there are now 10 states in addition to the District of Columbia that have something similar to this.

My understanding is that the Administration on Aging has used Title IV funds in one of those states, Missouri, to try to move this project along. So, it is something that is already receiving some support through the Older Americans Act.

I am wondering a couple of things. First, I do not know if anybody has looked into these problems, but one of the things that came to mind when I looked at it was: Does this create any liability problems for the Agency or the program manager who participates in the program and matches the person who needs care with the caregiver.

Mr. **Wyden**. Let me touch on liability and even back up a step. The way I understand it, there are four programs that have actually passed enabling legislation. The District of Columbia is the one furthest along in terms of funding.

Then in several other states, which I think is how we get to 10——

Mr. **Tauke**. Right.

Mr. **Wyden**. California, Massachusetts, Illinois, Colorado, New Jersey, Georgia and Maryland, is where legislation is pending.

Mr. **Tauke**. Right. I think you are correct in that.

Mr. **Wyden**. Yes. At this point, that is where we are.

Now, with respect to the liability problem, I think that is a very significant question. I have been talking with the senior program administrators. Because it would be an Older Americans Act program, it could be dealt with from the liability standpoint under the Older Americans Act.

They have purchase policies. There are a variety of arrangements that have been used to deal with it. We know the whole volunteer sector is facing serious problems with liability coverage. And our colleague, John Porter, has a very good bill to try to deal with some of this.

So, I think for purposes of this experiment, one would tie this new initiative into the insurance coverage for an Area Agency on Aging, a senior center they have existing now. I am told that can be done because it, in effect, is part of the ongoing Older Americans Act packet.

Mr. **Tauke**. The second question I had relates to how do you determine who gets volunteer credit? Let us say you have people who are now volunteering at a local nursing home. Would they be able to qualify for volunteer credit or would the local Area Agency on Aging have to certify a program as qualifying for the credit? How do you envision that?

Mr. **Wyden**. Well, I think, particularly, as we go through the demonstration project period, we should look at some of those issues. My general feeling is we should be primarily trying to look at new volunteers because that addresses the central concern, which is to try to get additional help to older people in their home.

Frankly, I think in the demonstration project context, maybe we ought to be looking at both. I think we should take an existing program and see what happens to it under the service credit concept. We probably should have a program or two where we say, "All right. This is going to apply to a new service credit." And that way we can test it out.

I guess I would be very concerned if all we were doing were replacing today's volunteers who do it without service credits with tomorrow's volunteers who do it with service credits. We will not have made an additional dent in trying to help.

Mr. **Tauke**. On the other hand, we would not want to undermine existing programs.

Mr. **Wyden**. Right. That's what I mean.

Mr. **Tauke**. What kind of steps can we take to avoid having a legal right attached to these volunteer credits?

Mr. **Wyden**. I think we have to simply state it. I think we have become far too legalistic a society as it is and I think the last thing we would want to see would be people going into Federal Court to sue over whether they had X-number of service credits or Y-number of service credits.

I think we want to make it clear that this is a volunteer-based program and one that does not attach legal rights that can be pursued. You can see what a horror story you would have: Someone going into Federal Court and saying that they had 12 hours of service credits and someone else saying they had only 8 point 5 hours of service credits coming. I just do not see it as anything that should be allowed. The purpose is to try to bring new recognition and stature to volunteers, to encourage some people to go to this home care field. I do feel this issue is one that we are all going to be grappling with for a long time. And I think it gives us a chance to test out an approach that could be helpful.

Mr. TAUKE. Have you given any thought to the question of mobility? Say—I am Local Senior Citizen in Dubuque, Iowa and I get tired of winters, although we did not have much of a winter this year, so, I decide to take off for Florida. And I have earned all these credits up in Dubuque, and now I get to Florida and two years later, lo and behold, I need some help. Have you given any thought to the issue of transferring credits?

Mr. WYDEN. Well, I think it is an idea we should look at. My only reservation about it is that it only works within a state. In other words, if you have lived in Dubuque and you moved to Cedar Rapids or Des Moines, then I think it works fairly easily because Area Agencies on Aging, have a rapport and the people know each other. If you try to transfer credits across the state lines, then you are getting toward a national approach that probably calls for a bigger Federal role than I would want to see.

I think that we should try to look at this as a local Area Agencies on Aging, senior programs. I think one of the things that I liked about it is that we could run it with the programs that are out there now. You do not have to go out and invent somebody new to run it.

I met with some people who are very active in the Area Agency on Aging in my state last Monday. And they said it would be very easy to add this on with the existing Older Americans Act. They said we take the same forms, we use the same materials, the same kind of recordkeeping. And they showed me how basically it was just adding a few lines for administration purposes to what they are doing now.

Mr. TAUKE. But the idea is to keep it simple.

Mr. WYDEN. Yes. Keep it simple and keep it tied to the existing network. Now, I do think within a state, you could—and that is appealing. At least in our state, someone may have worked in Portland, retired to the Oregon coast and that kind of thing. I am sure that is true in a lot of states. But once you go from one state to another, it seems then you are getting more involved.

Mr. TAUKE. Thank you, Mr. Chairman. And thank you, Mr. Wyden.

Mr. KILDEE. I was going to ask that question, too. It seemed that if you allow total mobility, one of the problems might be that in Florida or Arizona you might have more earned credits than earners of credits. You would have a problem there.

Congressman Wyden, I really appreciate your testimony this morning. Your involvement with the Gray Panthers in Oregon, and your advocacy here in the Congress have earned you great credentials. You are a person with a great head and a great heart which we need here very badly and we thank you very much for your testimony.

Mr. WYDEN. Mr. Chairman, it is always a pleasure to be with you and my friend from the Commerce Committee, Mr. Tauke. I look forward to working with you on these and many other issues.

Mr. KILDEE. Thank you very much.

I want to thank all our witnesses, today, for their testimony. You have been very helpful to us and we will continue to draw upon your expertise. And the hearing record will be remain open for two additional weeks. And at that, this hearing will stand adjourned.

[Whereupon, at 12:05 p.m., the subcommittee adjourned, subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Administration on Aging

Office of Assistant Secretary
Washington DC 20201

MAR 24 1987

Honorable Dale E. Kildee
Chairman, Subcommittee on Human Resources
Committee on Education and Labor
House of Representatives
Washington, D.C. 20515

Dear Mr. Kildee:

Thank you for the opportunity to meet with you and members of the Subcommittee to discuss the reauthorization of the Older Americans Act. I appreciated hearing your views on this important piece of legislation and look forward to working with you and members of the Subcommittee as deliberation on the bill continues.

Enclosed as promised are the following:

1. Community Checklist for an Aging America.

2. Sample copies, fact sheet and my statement on the caregivers' guide Where to Turn for Help for Older Persons. I have also included one camera-ready copy of the guide and can forward more should anyone on the Subcommittee wish to print and distribute the document.

3. Aging Magazine.

Again, I look forward to working with you and the Subcommittee to assure that each and every community in this nation is a good place to live and mature today and in the future.

Sincerely,

Carol Fraser Fisk

Carol Fraser Fisk
Commissioner on Aging

Enclosures

COMMUNITY CHECKLIST FOR AN AGING AMERICA

All older people should be able to live independent and dignified lives in their own community for as long as possible today and in the future. Every community should have a system of services and opportunities to help older people serve and be served where they live. Older people, their family and friends must be familiar with the system and feel that it responds to their needs.

How does your community rate in achieving this goal?

1. Does your community have a visible point of contact where anyone can go or call for help, information or referral on any aging issue? ( )
2. Does this point of contact lead to a range of options or a continuum of care including jobs, leisure activities, volunteer opportunities, suitable housing, in-home services, transportation, quality institutional care and other options? ( )
3. Is this range of options accessible to all older persons—the independent, semi-independent and totally dependent, no matter what their income? ( )
4. Are all resources - public, private, voluntary and personal—committed to supporting the system of options for older people? ( )
5. Does collaborative decision-making between public, private, voluntary, religious and fraternal organizations and older people exist in your community? Are all those concerned with older people working together in your community? ( )
6. Is there special help or targetted resources for the most vulnerable older people, those most in danger of losing their independence? ( )
7. Is there good referral from agency to agency to assure that information or assistance is received, no matter how or where contact is made in the community? ( )
8. Is the system in your community flexible enough to respond with appropriate individualized assistance, especially for the vulnerable older person? ( )
9. Is your response to the aging of our nation tailored to the unique nature of your community? ( )
10. Is there leadership in your community to convene all interested persons, assess needs, design solutions, track overall success, stimulate change and plan community response today and in the future? ( )

For more information, or assistance, contact:

- Your Area Agency on Aging
- Your State Unit on Aging
- The U.S. Administration on Aging
  330 Independence Avenue, S.W.
  Washington, D.C. 20201
  (202) 245-0011

Aging America
IT'S EVERYONE'S FUTURE

November, 1986

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

UNITED STATES COMMISSIONER ON AGING
CAREGIVERS GUIDE STATEMENT

People concerned with helping caregivers find resources and assistance for older people will be pleased to know that the United States Administration on Aging has just completed a brief but comprehensive guide entitled "Where to Turn for Help for Older Persons." The pocket-sized guide is a generic, layman's guide to resources for older persons for any community in the nation. It will help caregivers who are working with and for an older friend or loved one, even if they live nearby or far across the country. This guide is available through the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20401, Stock Number 01706200139-1, for $1.75 per copy. Agencies, organizations and businesses are encouraged to reprint the document for distribution on a national, regional or local scale. Anyone who will print the guidebook for their employees, clients or customers is urged to contact the Administration on Aging directly. Camera-ready copies are available for this purpose. Please write:

CAREGIVERS' GUIDE
U.S. Administration on Aging
330 Independence Avenue, S.W.
Washington, D.C. 20201

Your support of this very important nationwide effort is appreciated.

Carol Fraser Fisk

October 1986

Carol Fraser Fisk
Commissioner on Aging

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Office of Assistant Secretary
Washington DC 20201

Administration on Aging

"WHERE TO TURN FOR HELP FOR OLDER PERSONS: A Guide for Action on Behalf of an Older Person"

Background Information

AUDIENCE

This generic booklet is for family members, friends and neighbors of vulnerable older persons who urgently need help in caring for older persons. It can be reprinted and distributed by an agency, organization and business for employees, clients, customers, or the general public.

NEED

There are 40 million older persons over the age of 60, many of whom have one or more chronic health problems which jeopardize their ability to live independently in their own home.

PURPOSE

The booklet helps family members, friends and neighbors gain quick, effective access to appropriate community resources by directing them to State and Area Agencies on Aging for assistance in linking with vital community resources. No matter where the interested party lives, readers will be able to contact the Area Agency on Aging in the community where the older person resides.

MARKETING

AoA has a very limited number of copies and will only furnish sample finished products and camera ready copies to those agencies and organizations who will potentially reproduce the booklet. AoA is developing plans with State and Area Agencies on Aging to find sponsors for underwriting the cost of reproduction and dissemination. We are launching this nationwide effort by contacting national organizations and associations, large business firms and others who will work with State and Area Agencies on Aging in reprinting this booklet for distribution on a national, regional or local scale. Individual copies may be obtained by contacting the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. Single copies cost $1.75. Orders of 100 copies or more receive a 25 percent discount.

APPEAL TO BUSINESSES AND ORGANIZATIONS

Our goal is to help vulnerable older persons by getting copies of this booklet into every household in the nation. We want to link families and friends to the support needed to help them care for their older loved one.

October 1986

Where to Turn for Help for Older Persons

A Guide for Action on Behalf of An Older Person

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Preface

This booklet is designed to assist you in finding help when you are faced with an *urgent situation* regarding an *elderly* family member, friend or neighbor. Keep this booklet in a place where you can find it for a quick reference when needed.

Often a crisis occurs for an older loved one who lives in a community other than the one in which you live—across the State, or across the nation. The information in this booklet is designed to provide you with guidance as to where to find help in the community where the older person lives.

The first section of this guide contains the most frequently asked questions or issues in the most significant life areas.

Become familiar with this booklet, and learn how to use it. It may make all the difference in a crisis for an older person that you care a great deal about!

Carol Fraser Fisk

Carol Fraser Fisk
U.S. Commissioner on Aging

User's Guide

Throughout this booklet there are references to the local **Area Agency on Aging**. These are local agencies designated by the Governor of each State to be concerned with all matters that relate to the needs of the elderly in the community. It is this agency that is most likely to be able to mobilize help in time of need in the community in which an older person lives.

Because of the large number of these local agencies around the nation, it is impractical to provide accurate addresses and telephone numbers in this booklet. Rather, you will be directed to the **State Agency on Aging** charged with managing these agencies. You only need to ask for the **Area Agency on Aging** responsible for the community or county in which the older person lives. The **State Agency** will supply you with the telephone number of the local agency.

You should then call the appropriate **Area Agency on Aging.** They will help you.

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FINANCES

1. Programs Under the Older Americans Act

There are a variety of services funded by the Older Americans Act which are available in each community through the **Area Agency on Aging.** These services, which are available to all older persons, include information and referral, homemaker/home health-aides, transportation, congregate and home delivered meals, chore and other supportive services. Contributions are encouraged; however, there is no fee for services under Older Americans Act programs. The types of services available vary in each community based upon the needs and resources of a given locality. Contact the **Area Agency on Aging** for information about obtaining these services.*

2. Social Security

Social Security is a national retirement income supplement available to nine out of ten Americans over 65 years of age (persons age 62 may qualify under certain conditions). Monthly benefits are available to workers upon retirement, to their dependents and/or survivors, and to the severely disabled.

Individuals who wish to apply for Social Security may write or telephone the local Social Security office for instructions on how to file a claim at least three months before becoming eligible for benefits. Spouses and widows/widowers may be eligible for special benefits, including death benefits. Individuals who are disabled before 65 may apply for Social Security disability benefits.

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*See page 37 for the telephone number of the agency to help you.

Older persons may have their Social Security checks sent directly to their bank by the United States Government. This prevents lost or stolen checks and eliminates a trip to the bank to deposit the check. Contact your local Social Security Office for information about direct deposit and ask your bank about this service.

3. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) assures a minimum monthly income to needy persons with limited income and resources, who are 65, blind or disabled. Eligibility is based on income and assets. Local Social Security offices take applications, help file claims and provide information about the programs.*

4. Medicare

Medicare is a Federal health insurance program which helps defray many of the medical expenses of most Americans over the age of 65. Persons eligible for Social Security may also apply for Medicare benefits.

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FINANCES

Older persons should apply for Medicare benefits three months prior to the 65th birthday. For information about how to apply for Medicare, telephone or contact the local Social Security office. Working persons over 65 are entitled to Medicare even though they do not apply for Social Security.

Medicare has two parts:

A. *Part A—Hospital Insurance*—Medicare Part A helps pay the cost of inpatient hospital care. In some instances, and under certain conditions, Part A helps pay for inpatient care in a skilled nursing facility, home health care and hospice care.

Older persons and their families need to be knowledgeable about Medicare coverage. Detailed information about Medicare benefits, including a number of pamphlets explaining coverage can be obtained from the local Social Security Office.

It is important that older persons and their families understand patients' rights under Medicare. Written material describing these rights should be provided to patients upon admission to a hospital. This is especially true since the number of days in the hospital paid for by Medicare is governed by a system based upon patient diagnosis and medical necessity for hospital care. Once it has been determined that it is no longer medically necessary for the older person to remain in the hospital, the physician will start the discharge process.

If the older person or the family disagrees with the decision to discharge the patient, the decision may be appealed. To initiate an appeal, the State's Peer Review Organization (PRO) must be contacted by the patient or the family. Each hospital has the name, address and telephone number for the PRO responsible for overseeing hospital inpatient services. Information about how to contact the PRO is available from the hospital administrator's office, social services or business office staff. The patient or family can obtain information about implementing appeal procedures from the PRO and should ask about time limits governing these procedures.

B. *Part B—Medical Insurance*—Part B helps pay for medically necessary doctors' services, outpatient hospital services and some other medical services. Enrollees must pay a monthly premium for Part B. Inquire at your local Social Security office for more information.

Medicare will pay for many health care services but not all of them. Medicare does not cover custodial care or care that is not determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury. In some instances, Medicare may pay for certain psychiatric services. Individuals should check with the local Social Security office to learn which services are covered.

It is possible to privately purchase supplemental health insurance. This is sometimes referred to as "Medigap." Before purchasing a policy, care should be taken to assure that the plan provides the coverage that the older person wants and needs.

5. Medicaid

Medicaid is a health care program for low income persons cooperatively financed by Federal and State governments. Administered by States, the program provides for medical services to eligible individuals. Benefits cover both institutional and outpatient services. However, the types of services covered may differ from State to State. For example, some States may provide psychiatric services for persons over 65. Each State has a set of criteria that establishes eligibility for services under this program.

Further information about the Medicaid Program is available at the local county welfare, health or social service departments or the **Area Agency on Aging.***

6. Other Types of Public Supported Programs

Other sources of public support include food stamps, Veteran's benefits, housing assistance and low income energy assistance for eligible older persons.

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Veterans, their widows or widowers, or parents of veterans with limited income may be eligible for benefits. Contact the local Veterans Administration for the details.

Older persons must apply in order to participate in any of the programs described above.*

7. Private Resources

Families need to determine whether an older person has accumulated private resources which can be used to help pay for the cost of care. These resources may include retirement plans, long term care insurance, equity in a home, Certificates of Deposit (CDs) and Individual Retirement Accounts (IRAs) as well as assistance from family members.

8. Home Equity Conversion

Home equity conversion is a program which enables the owner to utilize the equity in a home for purchase of needed services. Some banks participate in this type of program and will arrange to free up these often overlooked resources to help cover the costs of services needed by the older person.*

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*See page 37 for the telephone number of the agency to help you.

FINANCES

9. Property Tax Exemption and/or Deferrals

Property tax exemption and/or deferrals are available in some communities to persons over 65 who have a limited income. Contact the local tax office for more information.

10. Tax Benefits

There are a variety of Federal, State or local tax benefits available to older persons. Contact the Internal Revenue Service, State and local tax offices for further information.

11. Senior Citizens Benefits

Many communities offer special discounts for goods and services to their senior citizens. Reduced prices may be offered through discounts on prescription drugs, transportation services, restaurant meals, recreation facilities, bank services and many other services.*

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*See page 37 for the telephone number of the agency to help you.

HEALTH

1. Health/Medical Services

Good health care is a very important factor in remaining as independent as possible. Health care, diagnostic and medical services can be obtained through a private physician. When necessary, the family physician can make referrals to a specialist, a hospital or other health services. In some communities doctors will make house calls.

Another approach to receiving health care and medical services is through membership in a Health Maintenance Organization (HMO). Contrary to a fee-for-services approach, HMOs provide care for a predetermined, fixed fee. The patient has a physician who provides and monitors care and, through the HMO, arranges for any additional health care, diagnostic and/or medical services that may be needed. A patient enrolled in an HMO plan must use the doctors and health care facilities covered by the HMO plan or must pay for medical services received outside the plan. Neither the HMO nor Medicare will pay the cost of services rendered by other physicians or facilities except in an emergency situation.

Other types of health care services that many communities offer include educational programs about good health habits, physical fitness, proper nutrition, screening programs for cancer, high blood pressure, diabetes, dental, vision and hearing problems, rehabilitation programs, and programs that monitor the status of chronic physical conditions.

Older persons and their families need to take an active role in selecting the most suitable facility and service to meet the needs of the older persons.*

2. Health/Psychiatric Services

Good mental health is an important factor in remaining independent for as long as possible. Mental health care and diagnostic services may be obtained through private means such as psychiatrists and psychotherapists. Other mental health professionals, such as psychiatric nurses and social workers provide help with emotional problems. Services may also be obtained through the local Community Mental Health Center, psychiatric hospitals, and at some community hospitals.*

3. Hospital/Emergency Services

Many older persons, at some point in time, may require acute care services such as hospitalization and/or emergency medical services. Physical and mental health services are usually obtained through the family physician or the Health Maintenance Organization. If a physician is not available, the patient may be taken to the emergency room of the local hospital. Ambulance services are available in most communities if the patient cannot be taken to an emergency room by any other means.

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Soon after a person is admitted to a hospital, the patient and family should be contacted by the discharge planner or social worker. If such contact is not made, inquiries should be made about discharge planning. Plans for the care of the patient, after discharge from the hospital, should be made as early as possible. Older patients and their families should be knowledgeable about Medicare coverage of hospital costs and patients' rights under Medicare. More detailed information about Medicare benefits and patients' rights is provided in the Finances section under Medicare. (See page 2.)*

4. Hospice

Hospice programs provide support and care for terminally ill persons and their families in the last stages of disease. These services, which include pain relief, symptom management and supportive services, are provided in the home with arrangements for inpatient care when needed.*

5. Nursing Home Care

Most older persons continue to live independently throughout all or most of their lives. For older persons who may need assistance, families are often able to provide the physical and emotional supports that are needed. However, in some cases when family supports are either not available or needs exceed what families can provide, it becomes necessary for the older person to move into a nursing home.

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*See page 37 for the telephone number of the agency to help you.

Different nursing homes offer different levels of care. The types of nursing homes include:

A. ***A Skilled Nursing Facility (SNF)***—is a nursing home which provides 24 hour-a-day nursing services for a person who has serious health care needs but does not require the intense level of care provided in a hospital. Rehabilitation services may also be provided. Many of these facilities are Federally certified, which means they may participate in the Medicare or Medicaid programs.

B. ***An Intermediate Care Facility (ICF)***—is also a nursing home which is generally Federally certified in order to participate in the Medicaid program. It provides less extensive health care than a SNF. Nursing and rehabilitation services are provided in some of these facilities, but not on a 24 hour-a-day basis. These homes are designed for persons who can no longer live alone but need a minimum of medical supervision or assistance and help with personal and/or social care.

C. ***Board and Care Facilities***—provide shelter, supervision and care, but do not offer medical or skilled nursing services. Unlike the SNF and ICF facilities, board and care facilities are not licensed to receive reimbursement under Medicare and Medicaid programs. In some States, the residents of board and care facilities may receive financial assistance through a State supplement to the individual's Supplemental Security Income (SSI) payment.*

D. *Choosing a facility*

☐ *Advance planning*

It is best to anticipate ahead of time that an elderly relative may need nursing home care. It is important for the older person to participate in the decision making process whenever possible. Early planning allows time for full exploration of the options available and will improve the chances of making appropriate decisions at the most appropriate time.

Three primary factors affecting the choice of a nursing home are the type of care required, the financial resources available and the convenience of location. In many States, pre-admission screening is required prior to admission to a nursing home. Information about choosing a nursing home can be obtained from the **Area Agency on Aging** in the area, information and referral agencies, local social service agencies, the Nursing Home Ombudsman, doctors, nurses, social workers, hospital discharge planners, clergy, friends or other families who have relatives in a nursing home. In addition, there are a number of publications available on nursing homes which may be found in a public library or book store.*

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*See page 37 for the telephone number of the agency to help you.

The first consideration in selecting a nursing home is to ensure that the facility can provide the type of care needed. Questions about what care may be needed should be discussed with the older person's physician.

The second prime factor is a frank analysis of the older person's financial status. There should be a complete inventory of available resources. This includes: source and level of income, property, savings accounts, stocks and bonds, veteran's benefits, pension provisions, insurance benefits and any family assistance available. If the older person can not afford to pay for nursing home care, hospital or local social services departments will provide information about eligibility requirements and procedures for applying for assistance from publicly financed programs. If an older person is unable to pay for nursing home care, the choice of a nursing home is limited to a facility which accepts Medicaid and has an opening.

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*See page 37 for the telephone number of the agency to help you.

The third factor is to decide on the best geographic location. The best choice is a facility which is most convenient to family and friends.*

☐ *Emergency Placement*

Many older persons and their families delay or avoid discussions and decisions about nursing home placement until failing health forces an immediate decision. If immediate help is needed in locating a nursing home or determining the quality of care provided in a particular facility, contact the **Area Agency on Aging** for assistance. Additional valuable information can be obtained through consultation with the physician, hospital discharge planner, State or local Nursing Home Ombudsman, local Social Security office, clergy and families of other nursing home residents.

Emergency placement in a nursing home is necessary in some instances if an older person is required to transfer from the hospital to a nursing home on short notice. Even under these circumstances, appropriate timing and arrangements for this transfer should be discussed with the physician and hospital personnel.

Even though the need for nursing home placement is urgent, it is still essential to consider the type of care needed, the finances available and the convenience of the facility's location.

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*See page 37 for the telephone number of the agency to help you.

E. ***Nursing Home Ombudsman***—The best way for families to assure quality care for an elderly relative in a nursing home is for family members and friends to continue to be involved with the older person through frequent visiting and good communication with the nursing home staff. If a question or problem arises regarding care of the nursing home resident, the first step in resolving the issue is to talk to the nursing staff or the social worker. If the issue continues to be of concern, the next step is to talk to the nursing home administrator. If these steps do not resolve the issue, the resident and/or the family may want to contact the Nursing Home Ombudsman who serves the community. The Ombudsman works with nursing home residents and families to negotiate a satisfactory resolution to questions and/or problems which have surfaced.

All States and many local communities have an Ombudsman who is responsible for investigating and resolving complaints made by or on behalf of residents in long term care facilities. The Ombudsman monitors the implementation of Federal, State and local laws governing long term care facilities. In many areas, the Ombudsman sponsors and encourages the development of local citizen groups to promote quality care in long term care facilities.*

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*See page 37 for the telephone number of the agency to help you.

F. ***Patients' Rights***—Persons entering a nursing home continue to have the same civil and property rights as they had before entering the home. Nursing homes participating in the Medicaid and Medicare programs must have established patients' rights policies. Ask the nursing home for a copy of its patients' rights policies. Contact the Nursing Home Ombudsman program for more information. The Ombudsman can be reached through the **State Agency on Aging.***

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*See page 37 for the telephone number of the agency to help you.

Community Services

1. Information and Referral

Most communities have agencies whose primary function is to provide people with information about where to go for the help they may need. If this type of assistance is required, a local **Area Agency on Aging** can help.*

2. Emergencies

Each community has an emergency number to dial in time of crisis. Check the telephone book or call the information operator for this number. It is helpful to post this number on each telephone for quick use in times of crisis.*

3. Transportation

There are services that can help in getting around in the community. A number of communities offer door-to-door transportation services for older persons such as vans or mini-buses which accommodate wheelchairs, walkers and other devices. Transportation may be provided to and from the doctor's office or other medical services; community facilities and other services.

Help may also be available in the form of escort services and shopping assistance.*

4. In-Home Health and Personal Care

Some older people may need help in the home with health care, such as taking medications, changing dressings, catheter care or other skilled nursing services. Others may need assistance with their personal care in the areas of bathing, dressing and grooming. Many communities have home health agencies that provide appropriate, supervised personnel to help older persons with both types of care.*

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*See page 37 for the telephone number of the agency to help you.

5. Homemaking, Home Maintenance and Chore Services

Services exist in many communities that help older persons with such activities as:

light housekeeping
laundry
shopping
errands
meal preparation
home improvement or maintenance
heavy cleaning
yard and walk maintenance.*

6. Home Improvement/Weatherization

Limited home improvement grants and/or loans are available to older persons who meet income eligibility guidelines under a federal block grant program. Funds can be used for roofing, ramps, and insulation.*

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*See page 37 for the telephone number of the agency to help you.

COMMUNITY SERVICES

7. Medical Equipment

Purchasing or renting medical equipment may become a necessity. In some cases, when ordered by a physician, rental or purchase of medical equipment is covered by Medicare or Medicaid. Some communities supply medical equipment through local voluntary agencies. In addition to the local **Area Agency on Aging**, the local health department may provide more information.*

8. Nutrition/Meals

Each **Area Agency on Aging** has information about group and home delivered meals that are available to older persons in the community. These programs help people maintain an adequate diet by providing a nutritious meal daily.*

9. Respite Care

There are ways that a relative can be relieved of caregiving duties for a short period of time. Some communities offer volunteer or paid respite care services which provide short term, temporary care for an impaired older person to relieve the family members who provide daily care to their relative.*

10. Adult Day Care Services

Adult day care services may be available in your community. This type of service provides social and some rehabilitative activities for the frail older person during the day in a community facility.*

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*See page 37 for the telephone number of the agency to help you.

11. Counseling

Communities often offer guidance and assistance for older persons and families in coping with physical impairments and such problems as substance abuse, financial crisis, bereavement and elder abuse.*

12. Support Groups

Groups have been formed in many communities that provide information and emotional support to older persons and/or their caregivers. These groups frequently focus on special needs such as Alzheimer's Disease, terminally ill persons, bereavement and other serious life situations.*

13. Reassurance

To reassure older persons living alone, many communities provide daily telephone contact, friendly visiting, the U.S. Postal Service's "Carrier Alert" program and emergency assistance programs.*

14. Social/Recreational Activities

Many communities support group activities for social, physical, religious, and recreational purposes. Senior Centers offer a good opportunity for recreation and social involvement with others. There are a number of other groups that focus on special interests such as arts and crafts, education, travel, and other interests.*

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LEGAL ISSUES

Many communities offer legal services. For those elderly who are unable to appropriately manage their own affairs, legal and/or protective services may be needed. Such services are designed to safeguard the rights and interests of older persons, to protect them from harm, to protect the property of older persons and to provide advice and counsel to older persons and their families in dealing with financial and business concerns. Many communities have a Bar Association which makes referrals to practicing attorneys. Some legal issues that older persons and their families may be interested in could include:

1. Power of Attorney

This is a legal device which permits one individual known as the "principal" to give to another person called the "attorney-in-fact" the authority to act on his or her behalf. The attorney-in-fact is authorized to handle banking and real estate, incur expenses, pay bills and handle a wide variety of legal affairs for a specified period of time. The Power of Attorney can continue indefinitely during the lifetime of the principal so long as that person is competent and capable of granting power of attorney. If the principal becomes comatose or mentally incompetent, the Power of Attorney automatically expires just as it would if the principal dies. Therefore, this Power of Attorney may expire just when it is most needed.*

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2. Durable Power of Attorney

Because Power of Attorney is limited by competency of the principal, some States have authorized a special legal device for the principal to express intent concerning the durability of the Power of Attorney to survive disability or incompetency. This legal device is an important alternative to guardianship, conservatorship, or trusteeship. The laws vary from State to State and since this puts a considerable amount of power in the hands of the attorney-in-fact, it should be drawn up by an attorney licensed to practice in the State of the client. This device is to compensate for the period of time when an individual becomes incompetent to manage their own affairs appropriately.*

3. Guardianship

Guardianship or conservatorship is a legal mechanism by which the court declares a person incompetent and appoints a guardian. The court transfers the responsibility for managing financial affairs, living arrangements, and medical care decisions to the guardian.*

4. Wills

A well prepared will is an effective tool which provides explicit instructions for the distribution of property and if appropriate, how that property is to be used after a person dies. Information about burial or cremation can also be included. A will designates an individual or individuals to serve as the executor(s) responsible for carrying out the instructions of the will. Generally, a will makes it easier to settle affairs more quickly and with less legal expense.

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*See page 37 for the telephone number of the agency to help you.

5. The "Right to Die": Living Wills

Public attention is increasingly focused on "right to die" issues as advancing medical technology makes it possible to sustain, almost indefinitely, some vestige of life in dying patients. The term "right to die" refers to individual decision making regarding the prolongation of life through the use of extreme measures. The instrument or legal provision which enables others to carry out a person's wishes regarding the non-use of extreme life sustaining measures is called a Living Will.

Many States have enacted statutes which enable persons to make a Living Will. A Living Will is a signed, dated and witnessed document which allows a person to state wishes in advance regarding the use of life sustaining procedures during a terminal illness. This document indicates the appointment of someone else to direct care if the patient is unable to do so. It should be signed and dated by two witnesses who are not blood relatives or beneficiaries of property. A Living Will should be discussed with the doctor and a signed copy should be added to the individual's medical file. A copy should be given to the person who will make decisions in the event that the older person is unable to do so. It should be reviewed yearly to make changes as needed.*

6. Other Issues

A. Issues concerning property, estates and trusts are governed by State laws and in some cases, local ordinances. If finances do not permit hiring a private attorney, there are programs that provide both legal advice and legal representation in court to elderly and low income persons. For information, contact the local Bar Association or **Area Agency on Aging**.*

B. Sometimes, tenant/landlord issues arise regarding leases, services, rental rights and obligations. To get advice, contact your landlord tenant advisory council, a lawyer, or the local **Area Agency on Aging**.*

C. Questions about family responsibility for financial support for health care, medical and/or long term care frequently arise. Families may need to seek legal advice about their obligations.*

D. It is important for the consumer to make informed choices when planning funeral ar-

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rangements. Collection of information on the cost of desired arrangements and preplanning can help families avoid hasty, and often times expensive, decisions. Consumers have a right to choose only those funeral and cemetery arrangements they desire. A new funeral rule specifies that funeral providers must disclose the cost of all goods and services, and upon the request of the consumer, must provide a written price list.

Families may choose to have traditional funeral services, direct interment, cremation and memorial services. Body or organ donation may be another consideration.

Availability of death benefits should be ascertained. In some cases, these benefits could have a direct bearing on planning funeral arrangements. Death benefits may be derived from Social Security, the Veterans Administration, life and casualty insurance and other sources depending upon the circumstances at the time of death.

Many older persons have specific wishes about how the funeral is to be conducted and burial arrangements. Those wishes should be put in writing and left where they can easily be found by a responsible family member.*

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SHELTER

1. Congregate and Senior Housing Apartments

Congregate and group living arrangements are available for rental to older persons in many communities. Some facilities are privately financed and others are publicly assisted. In those communities which have congregate living facilities for low income older persons, application for a subsidized rental unit is made through the local Housing Authority.*

2. Accessory Apartments

An accessory apartment is an independent living unit with its own outside entrance, kitchen, and bath. Accessory apartments may be especially desirable for younger families who want their older relative(s) near, or for older residents of large houses with space that could be converted into an accessory apartment.*

3. Retirement and Life Care Communities

There are a variety of retirement and life care communities available in different parts of the country. Many retirement communities offer single family dwellings, rental apartments, condominiums and cooperatives which are sold or rented in the usual manner. In many of these communities, only the usual community services such as police and fire protection, are available to residents. Other communities offer transportation, home delivered meals, and some in home services. It is important to inquire about what services are available and whether there are additional fees for these services.

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*See page 37 for the telephone number of the agency to help you.

In some parts of the country, living arrangements referred to as "life care communities" are available. In these communities, the resident, upon application, makes a one time payment and agrees to pay a monthly fee for services provided. The initial payment may range from $15,000 to $175,000 or more, depending upon the location and amenities offered. Monthly fees may range from $150 to over $2,000 or more for maintenance, chore services, housekeeping, meal and other personal care services. Many of these facilities have a "graduated care" arrangement which permits the resident to move from their own apartment into a nursing home unit, which includes skilled nursing home care, if needed. Frequently, these units will arrange for basic medical services. State and local regulations and requirements governing the operation and financing of these facilities vary considerably. Some States have no regulations or requirements regarding such facilities while other States prohibit the development of such facilities.

Facilities which are well designed and

carefully administered offer comfortable and independent living to many older persons. In all instances, if a family is considering this as a desirable housing alternative, an on-site visit to the facility and careful checking into the financial solvency of the organization is a *must*. Before entering into any contractual arrangements with such a facility, an attorney should be consulted.*

4. Shared Housing and Home Matching Programs

Shared housing is a living arrangement in which two or more unrelated individuals share the common areas of a house or apartment, while maintaining their own private space such as a bedroom. In home matching programs, potential home or apartment sharers are introduced to home or apartment seekers. Shared housing arrangements have three primary benefits. Financial benefits are derived from pooling resources to pay the rent, utilities, and other expenses associated with maintaining a home. A second benefit results from sharing the responsibilities for homemaking chores with others. Social interaction with other residents of the shared house is a third important benefit. Arrangements for shared housing can be made by individuals or by a public or private agency.*

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*See page 37 for the telephone number of the agency to help you.

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5. Echo Housing and Mobile Homes

Echo housing or "grannie flats" are usually small living units in the back or side yards of a single family home. A mobile home can offer many of the same advantages of proximity to the family that echo housing does. However, zoning restrictions may prohibit such an arrangement in urban areas.*

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*See page 37 for the telephone number of the agency to help you.

State Agencies on Aging

In which state is the community you are concerned with located? Find the state below and call the agency listed. It will provide you with the telephone number of the **Area Agency on Aging** for that community. Call that agency to get the help you need!

State Agency:	Telephone Number:
Alabama Commission on Aging	(205) 261-5743
Older Alaskans Commission	(907) 465-3250
American Samoa Territorial Administration on Aging	(684) 633-1252
Arizona Office on Aging and Adult Administration	(602) 255-4446
Arkansas Department of Human Services	(501) 371-2441
California Department of Aging	(916) 322-5290
Colorado Aging & Adult Services Division	(303) 866-5122
Connecticut Department on Aging	(203) 566-3268

State Agencies on Aging

Delaware Division on Aging	(302) 421-6791
District of Columbia Office of Aging	(202) 724-5622
Florida Aging and Adult Services	(904) 488-8922
Georgia Office of Aging	(404) 894-5333
Guam Public Health and Social Services	(671) 734-2942
Hawaii Executive Office on Aging	(808) 548-2593
Idaho Office on Aging	(208) 334-3833
Illinois Department on Aging	(217) 785-3356
Indiana Department on Aging and Community Services	(317) 232-7006
Iowa Commission on Aging	(515) 281-5187
Kansas Department on Aging	(913) 296-4986
Kentucky Division for Aging Services	(502) 564-6930
Louisiana Governor's Office of Elderly Affairs	(504) 925-1700

State Agencies on Aging

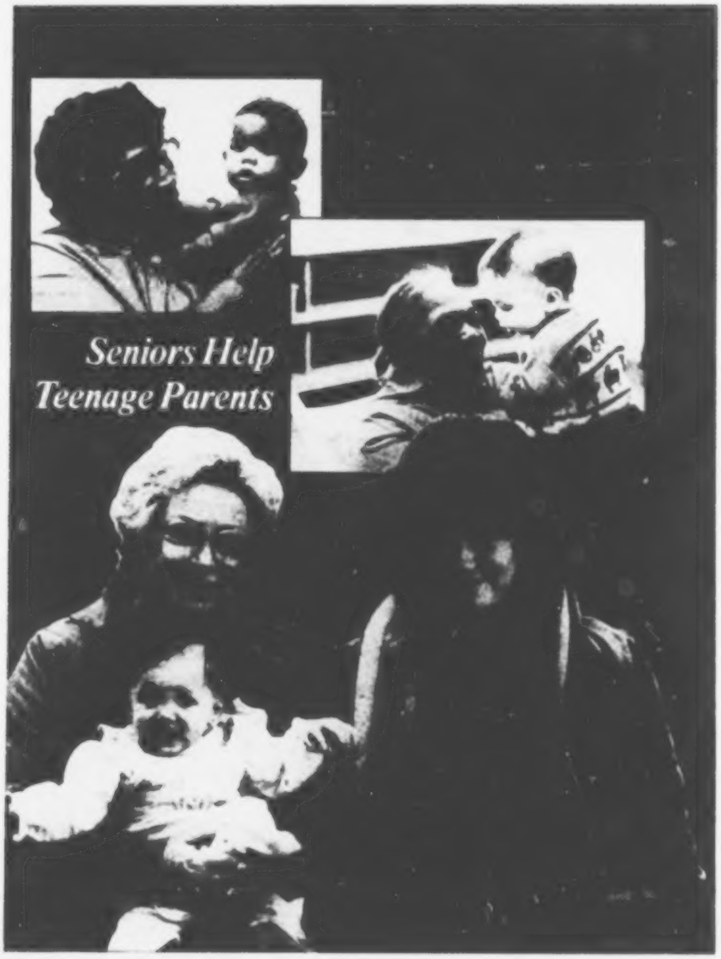
Maine Bureau of Elderly	(207) 289-2561
Maryland Office on Aging	(301) 225-1102
Massachusetts Department of Elder Affairs	(617) 727-7751
Michigan Office of Services to the Aging	(517) 373-8230
Minnesota Board on Aging	(612) 296-2770
Mississippi Council on Aging	(601) 949-2013
Missouri Division of Aging	(314) 751-3082
Montana Community Services Division	(406) 444-3865
Nebraska Department on Aging	(402) 471-2307
Nevada Division for Aging Services	(702) 885-4210
New Hampshire State Council on Aging	(603) 271-2751
New Jersey Division on Aging	(609) 292-4833
New Mexico State Agency on Aging	(505) 827-7640

State Agencies on Aging

New York State Office for the Aging	(518) 474-4425
North Carolina Division of Aging	(919) 733-3983
North Dakota Aging Services	(701) 224-2577
Northern Mariana Islands Department of Community and Cultural Affairs	(670) 234-6011
Ohio Commission on Aging	(614) 466-5500
Oklahoma Services for the Aging	(405) 521-2281
Oregon Senior Services Division	(503) 378-4728
Pennsylvania Department of Aging	(717) 783-1550
Puerto Rico Gericulture Commission	(809) 724-1059
Rhode Island Department of Elderly Affairs	(401) 277-2858
South Carolina Commission on Aging	(803) 758-2576
South Dakota Office of	(605) 773-3656

State Agencies on Aging

Adult Services and Aging	
Tennessee Commission on Aging	(615) 741-2056
Texas Department on Aging	(512) 444-6890
Trust Territory of the Pacific Islands Office of Elderly Affairs	(670) 322-9328
Utah Division of Aging and Adult Services	(801) 533-6422
Vermont Office on Aging	(802) 241-2400
Virgin Islands Commission on Aging	(809) 774-5884
Virginia Department for the Aging	(804) 225-2271
Washington Bureau of Aging and Adult Services	(206) 753-2502
West Virginia Commission on Aging	(304) 348-3317
Wisconsin Office on Aging	(608) 266-2536
Wyoming Commission on Aging	(307) 777-6111



Seniors Help Teenage Parents

Commissioner's Corner

Carol Fraser Fisk

On any given day, the Administration on Aging is sure to receive anxious letters and phone calls from people across the country who want to know where to find help for an older relative who is ill. Or the problem may be about some other serious situation—legal issues, finances, housing, nursing home care, community services.

AoA has published a booklet that we hope will be invaluable to caregivers who seek answers to these or other urgent questions. The title of the booklet is apt and to the point: *Where to Turn for Help for Older Persons.* A pocket-size guide written in everyday language, the booklet is primarily aimed at those who care for older people who may need assistance from one of the 724 State and Area Agencies on Aging across the country. The guide places special emphasis on help for older people who have chronic health problems which jeopardize their ability to live independently in their own homes.

As one who has had personal experience with the frustration and confusion of trying to find help for older loved ones in a time of crisis, I can testify to the importance of educating Americans about services that are available to elderly relatives in their own community. That is why I would like to see a copy of this booklet in every household in this country. The booklet is a guide to action. It helps family members, friends and neighbors gain quick, effective access to appropriate community resources by directing them to State and Area Agencies on Aging for assistance. No matter where the interested party lives, readers will learn how to contact the Area Agency on Aging in the community where the older person resides.

In order to achieve the widest possible distribution of this guide for action, I have directed the Administration on Aging staff to develop plans with State and Area Agencies on Aging to find sponsors for underwriting the cost of reproduction and dissemination of the booklet. AoA has already launched this nationwide effort by contacting national organizations and associations, large business firms and others who will work with State and Area Agencies on Aging in reprinting this booklet for distribution on a national, regional or local scale.

Anyone interested in reprinting the guidebook for employees, clients or customers should contact us for camera-ready copies available for this purpose. For further information, please call Irma Tetzloff at AoA (202) 245-2205, or write: Caregiver's Guide, U.S. Administration on Aging, 330 Independence Ave., S.W., Washington, D.C. 20201.

The booklet is available for sale to individuals from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Single copies are $1.75, with a 25 percent discount on orders of 100 or more. Please ask for stock #017-062-00139-1.

Making contacts early in 1987 with organizations and businesses to enlist their support in reproducing *Where to Turn for Help for Older Persons* would be an excellent first step in planning activities for Older Americans Month in May. The theme selected for this year's celebration is "Make Your Community Work for Older People," a goal that certainly cannot be accomplished without making services visible and accessible to older people and their families. The new pocket-size guide contains information that every family ought to have about the network of agencies serving our nation's elderly.

Plans for Older Americans Month emphasize the importance of developing systems of community-based services that are responsive to the needs of older people and their families. An eye-catching Older Americans Month poster is on the drawing boards, and a Presidential Proclamation will be issued.

AoA will also disseminate a media kit highlighting activities that agencies on aging, businesses, national organizations and community groups can undertake to strengthen the system of services for older people. I urge you to begin thinking now of new activities and partnerships that will "Make Your Community Work for Older People."

To our readers . . .

With this issue, Aging will be published quarterly, and price has been reduced from $15 to $5 a year. If you subscribed or renewed at the higher price, you will receive additional issues of the magazine on a prorated basis.

Aging

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration on Aging

Dedicated and reliable, the foster grandparents [illegible] for the teenagers. 2

The frail elderly simply don't have the energy to advocate on their own behalf. 10

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Three Generations of Love

Foster Grandparents and teenage parents are a natural combination

Foster Grandmother Mary Wales with 17-year-old Lisa McGrath and her baby Alicia Johnson at the Child Care Center.

Photos: Joe E. Kennedy

By Nancy Walls

We have all heard statistics over the last few years about the rapidly growing number of older adults in this country. In recent times, we have also been hearing more and more about the problems of teenage parents. Nationally, about one-fifth of all births are to teenagers.

Thus, we have two separate populations, each having its own special needs—the older adults needing some meaningful activity to occupy their time and the teen parents needing understanding and guidance in the raising of their children. What better way to help both groups than to match them up and let them help each other.

This is precisely what has been done in Wayne County, Michigan, with the Foster Grandparent Program of Wayne and Macomb Counties and three local teenage parent programs. Currently, there are 15 foster grandparents working in the three programs—two of which are located in Detroit and one in the suburb of Lincoln Park. In addition, there are two foster grandparents placed in a teen parent transitional group home located in the suburb of New Boston.

A School Child Care Center

Since the three in-school programs are similar in design, this article will focus on only one program—The Teenage Parent Alternative School Program (TPASP) in suburban Lincoln Park. Started in 1972, the program is operated by the Wayne County Intermediate School District in conjunction with 14 local school districts and community agencies. It has been singled out as a Model Program by the State Department of Education and funded as a Demonstration Project by the Office of Adolescent Pregnancy Programs in the U.S. Department of Health and Human Services.

Eligible students include pregnant teenagers and school-age mothers and fathers and their children from the 14 participating school districts. The primary goal of the TPASP is the provision of comprehensive services to allow the teen parents to stay in school and earn a high school diploma. Besides academics, services include prenatal/postnatal health counseling, pediatric health care, mental health counseling, social service resource information and referral, child care services, parenting classes, vocational training, job preparation and placement, and a transitional housing arrangement.

The Child Care Center, which is open every day to allow school-age parents to attend classes, is licensed to serve children ages two weeks to five years. Students also receive hands-on child care experience in a daily 1-hour required class at the Child Care Center.

It is here in the Child Care Center that the foster grandparents are assigned. Every weekday morning, the blue Foster Grandparent Program van pulls up in front of the school, and nine older women emerge in their bright red smocks, eager to begin their 4-hour day.

One or two foster grandparents work in each of the five child care rooms, which are divided according to age and/or development of the child. They are assigned to work with two children, often those who have a special need for love and attention. The grandparents and the other child care workers play with the youngsters, feed them, take them for walks and, generally give them a great deal of tender loving care. When the teen parents are in the room, foster grandparents talk with them, listen to their problems and provide them with support.

Edna Lee Taylor, 70, puts Debra Kemnitz, 1-1/2 months, in the swing.

One of the factors that has made this association so positive is the dependability of the foster grandparents. TPASP staff have remarked on many occasions how important consistency is for the teens and their children. Although TPASP has had other volunteers, they did not achieve the dedication of the foster grandparents, whose reliability provides an excellent role model for the teenagers.

The grandparents are able to provide a nonjudgmental ear and an arm around the shoulder when the teen parents need it. One foster grandmother, Mrs. Mary Frances Wales, comments that several of the teens enjoy talking with her about boyfriends or problems they might be experiencing. She says, "I see this as part of my responsibility, to listen to their problems and hope that I have been helpful to them." Many of the teens have told her that since she has lived longer than they have, they respect her views on situations.

Drema Raupp, director of the TPASP, believes that "the intergenerational approach to parenting is the best approach." She feels that the teen parents and their children both benefit a great deal from having contact with the older age group. Most of the teenagers don't have extended families and this allows them to experience another generation's view of life—a generation with which they would otherwise have little or no contact.

A Sense of Family

A sense of family is important to the teenagers, and Mrs. Raupp believes this is created by the mere presence of the foster grandparents. They are always accepting of the teens and are willing to listen and help. The teens intuit this and, as a result, they have formed some close relationships with the grandparents.

This was particularly evident one summer when a foster grandparent, Mrs. Mary Sanders, was placed in the private home of a teen parent and her husband. The young parent was experiencing some difficulties in coping with the stress of being a new mother and wife, and it was felt that she needed the continued support of the foster grandmother after school closed for the summer.

During staff visits to the house, it became apparent that a deeper relationship was forming. Not only did the teen respect the foster grandmother's child care knowledge and experience, but she also appreciated her companionship.

Mrs. Sanders also grew from the friendship. By developing a closer relationship with one of the young parents, it helped her to understand some of the other teens even more. Because the home setting provided an atmosphere more conducive to bonding, Mrs. Sanders stated that she felt more needed in the home.

When summer ended, the grandmother, the teen and her son returned to the school. By the next summer, the girl had graduated, but the experience had been so positive that she very much wanted to have Mrs. Sanders in her home again. In fact, Mrs. Sanders continues to receive cards and occasional calls from the teen parent to this day—two years after the summer placement.

Other foster grandparents have formed close relationships within the school setting. Genevieve Weaver, a foster grandparent, comments that even though the teen parents may, at times, seem to be distant from the grandparents, there appears to be an "understanding" between the two groups. It is an understanding that somehow binds them without spoken words. It can be seen in the smile on a teen parent's face when the grandmothers arrive; in the hugs and pats on the back exchanged over important accomplishments; in the birthday, Christmas and thank-you cards received by the grandparents.

To some of the young parents, the foster grandmothers take the place of the grandmother whom perhaps they never knew or didn't often see. The grandparents, on the other hand, take great pride in "their" grandchildren, giving glowing reports to others of what "their" grandchild learned to do that day.

The work is very important to the older women. Not only are they keeping themselves busy and useful by volunteering, but they are also forming new friendships and sometimes even creating new "families." For some of the grandparents, working at the school is their main social outlet. They have little contact with their families, so the program fills a void in their lives. Edna Lee Taylor, a foster grandparent, says that she feels the teens are like her own grandchildren and their babies like her own great-grandchildren. Her real family is in another state, so her "foster" family is very important.

When asked what the program means to her, foster grandmother Shirley Ortkras is more than a little enthusiastic: "I'm reborn! It takes me out of my apartment for four hours. I was a very lonely, lonely person before I joined." She recalls with plea-

Cora Ross, 72, plays with Adam Shamon.

sure her return to the school after a few days vacation. When she entered the room, two or three of the children ran to her excitedly, saying, "Grandma's back!"

Group Home for the Teens

The TPASP also runs a group home for teenage parents and their children. It became apparent that housing for the students was a big problem. Some were living in less than ideal conditions, others really had no place to go at all. After a battle with authorities to make establishment of a group home a priority, Mrs. Raupp finally received some funding from the Department of Social Services' teen pregnancy initiative.

After much hard work renovating an old carpenter's shop, "Sunshine House" was finally established in a rural community about 20 miles from the school. Other housing possibilities for TSAP students are investigated first, but if no other options are available, the student is recommended for Sunshine House. While there is no maximum length of stay, the staff is constantly helping the teens to work toward the goal of independent living.

The home has private bedrooms for six girls and their children, with the rest of the living quarters shared by all the residents. To supervise activities, the TPASP has houseparents, a couple with three children of their own, who live in the apartment above Sunshine House. The houseparents help coordinate cooking, cleaning and other daily activities, making sure that things run smoothly.

Foster grandparents have been involved with Sunshine House ever since it opened three years ago, and there are currently two grandparents working with the young parents and their children. Their role is somewhat different from their counterparts' in the school setting because of more intense involvement with the teenagers.

Dorothea Sharpe, 67, holds Matthew Canady.

Drema Raupp feels the grandparents offer an irreplaceable service at the house. She explains that the teens at Sunshine House are more needy, emotionally, than most of the other students at the school. Not only do these teens have to cope with the typical problems of being a teenage single mother, but they have other serious family problems that have left them with no place to live. With fewer adults in their lives, the foster grandparents become doubly important.

The grandparents are there everyday when the teenagers come home from school to hear about their problems and their accomplishments. The grandparents feel especially needed because they are so involved in the day-to-day lives of the girls and their children.

A Wonderful Idea

The merging of these two programs—Foster Grandparents and Teenage Parents—has certainly been a worthwhile experience for everyone involved. The teens have found friendship and have learned the value of communication with all age groups. The babies and toddlers have benefitted from the loving touch of experienced hands. The foster grandparents feel satisfied that they have been active in helping to improve the quality of life for the teens and their children. This, in turn, has improved the quality of their own lives as well. Foster grandmother Edna Lee Taylor says it can be summed up in one word— "wonderful!"

For further information, contact Nancy Walls, Foster Grandparent Program, 9851 Hamilton, Detroit, Mich. 48202 (313) 883-2100 ext. 228. ■

Nancy Walls is a Field Supervisor for the Foster Grandparent Program of Wayne and Macomb Counties in Detroit, Michigan. Also contributing to this article was Jane Kubisiak, another Field Supervisor with the Foster Grandparent Program.

Rose Finally Unpacked Her Belongings

by Janet B. Kurland and Gail E.J. Lipsitz

An apartment management firm teams up with a social service agency

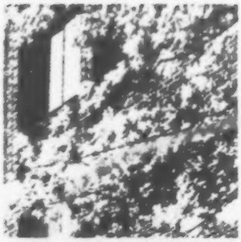
5900 PARK HE

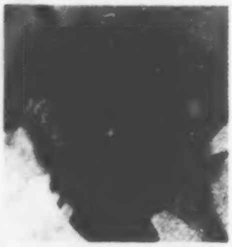
There's more to managing senior high-rise apartments than fixing leaky ceilings and applying fresh coats of paint, as Wallace H. Campbell and Company is demonstrating in Baltimore, Maryland.

Concerned about the needs of tenants who were growing more frail as the years went by, the Campbell Company has been working with Jewish Family Services and the Jewish Community Center to provide supportive services to high-rise residents in a project funded by the Administration on Aging (AoA). The two agencies are part of Associated Jewish Charities of Baltimore.

The AoA grant was awarded to the Maryland Office on Aging in the fall of 1985 to demonstrate how the corporate community and private nonprofit agencies could work together to meet the needs of older people. The Campbell Company was a logical choice for such a project since the firm was already managing a building for a nonprofit group called CHAI (Comprehensive Housing for the Aged), which is also affiliated with Associated Jewish Charities.

Like the other two senior high rises managed by the Campbell Company, the CHAI building was originally de-





signed for a reasonably healthy population of seniors capable of independent living. But tenants who had moved in as well-functioning, self-directed individuals were experiencing illness and other stresses leading to physical and emotional disability and social isolation. This "aging in place" phenomenon, coupled with the increasing difficulty families were having in meeting the needs of frail relatives, created an increasing number of requests for help from Jewish Family Services. Also contributing to the tenants' need for assistance were the new prospective pay regulations for hospitals which have resulted in more restricted hospital admissions and earlier discharges.

CHAI's Board of Directors worked with the Campbell Company to make available the Jewish community's network of services, particularly the counseling and homemaker services of Jewish Family Services and the social and recreational programming of the Jewish Community Center.

The close cooperation of the Campbell Company with CHAI demonstrated how real estate management skills could be integrated with a social orientation and philosophy. The management company came to understand the critical need for early diagnosis, counseling and supportive services as well as social interaction and activities in maintaining the physical and emotional health of elderly tenants. Most important, the company realized that management has a responsibility to be responsive to those needs.

Frail Tenants Identified

When the federal grant monies became available in 1985, the Campbell Company welcomed the opportunity to apply the model of service delivery being used effectively at the CHAI-operated building to two other congregate apartments under its management in Northwest Baltimore. Although residents of these buildings were receiving emergency services, access to meals, some special group activities, and referral to social services, a more intensive program was needed.

After receiving the federal grant, the management company entered into a contractual arrangement with Jewish Family Services (JFS) and the Jewish Community Center (JCC) to provide the necessary social and supportive services. JFS' role in the project is to identify frail tenants and assess their physical, emotional, and social needs. Once vulnerable residents are identified, social workers assigned to these buildings provide casework services, including information and referral, crisis intervention, short-term counseling, case management, family liaison work, and client monitoring and advocacy. Selected residents may also receive home care and emergency response equipment.

Rebecca Kovitz and her homemaker Nellie Johnson from Jewish Family Services.

The Jewish Community Center provides recreational, educational, cultural, and social group activities for residents. For example, an exciting program was arranged for Independence Day by the JCC in cooperation with the Jewish War Veterans, who presented an American and a Maryland state flag to the residents of one of the apartment buildings. Over 85 tenants, 17 of whom were newly naturalized citizens, attended the evening festivities with refreshments served by the nutrition program, "Eating Together of Baltimore City." The JCC also arranges small group programs for the impaired elderly with special needs, including socialization, light exercises, drama, and arts and crafts.

The Campbell Company has overall responsibility for coordinating the project. Group programming and individual services for the residents are planned through monthly meetings of JFS, the JCC and the Campbell Company, as well as through frequent meetings with apartment managers, nutrition program managers, and other community agencies and organizations involved.

Since October, 1985, the project has provided outreach to all 300 residents of the two buildings and completed 155 screening interviews. Direct casework services have been provided to 49 people who were identified as needing immediate intervention.

Rose Was Still Depressed

Rose Gordon was one of the tenants needing help, but she was probably afraid to admit that to herself, let alone to anyone else.

Rose Gordon and her husband, Jack, had a dream that once the children were grown and settled, they would live in their home, tend their garden, take classes, travel and enjoy their retirement years. Their dream came true, lasting for 12 years. Then Jack became ill and died. For the next 7 months Rose remained in their home, until she, too, began to develop health problems. When she could no longer maintain her home by herself, she decided to sell it and move into a neighborhood senior high-rise building.

Rose was referred to Jewish Family Services by the manager of her apartment building. The manager noticed that Rose came to the nutrition program infrequently and was often not present at special group activities. Even more troubling to the manager was the fact that Rose rarely appeared in the lounge area. When she did appear, she always looked sad, and she seemed especially reticent about allowing anyone to visit with her in her apartment. The manager asked Rose if she would consider talking to a social worker.

When Rose consented, a JFS social worker contacted her and arranged an office visit and assessment. Later Rose agreed to a home visit. The worker found that Rose's apartment was still filled with many unpacked

boxes from her move; the dining table was covered with papers including unopened mail. Also, Rose complained of some continuing physical problems.

JFS connected Rose with medical services in the area, defined and implemented a financial management plan, initiated appropriate home care services, and helped her to begin socializing (in cooperation with the JCC). The social worker arranged bereavement counseling to help Rose accept her husband's death. Supportive counseling was also provided by a trained volunteer from the Northwest Senior Center's "Peers in Passage" program, a network of older people who offer support to their peers during periods of change in their lives.

As a result of the manager's astute observations and appropriate referral, JFS was able to develop and implement a comprehensive service package for Rose. She was finally able to unpack her belongings and to begin to feel at home. She has become an active participant in many of the apartment activities and is starting to make new friends.

Manager Training Curriculum

One reason why JFS could help Rose so effectively was that her building manager had participated in the special in-service training series JFS provides for the managers of apartment buildings housing elderly tenants. The training curriculum is designed to educate managers about the conditions and needs of elderly residents. Topics include the biological, psychological and social aspects of the normal aging process; loss and bereavement; and community resources. Special emphasis is placed on crisis intervention skills to help the managers better understand and cope with the diverse situations that confront them every day. Case vignettes stimulate discussion of possible problem-solving strategies.

Because of its success, in-service training has now been extended to the managers of other high-rise buildings under the Campbell Company's management. In addition, the curriculum is likely to become a model for the State of Maryland, since the 1986 Maryland General Assembly passed a bill requiring the Maryland Office on Aging to establish a training series for managers of senior adult housing facilities. JFS was active in advocating this legislation and is looking forward to helping further with the development of the program.

Photos: Ron Soloman

Social worker Shana Goldfinger shows Mrs. Ethel Berman how to work the emergency response system.

In addition to the range of services already described, the Campbell grant has made possible several special programs for the elderly people being served. Five residents have received 24-hour emergency response units leased from the "Voice of Help" program sponsored by a local hospital. Already, one person has received immediate emergency medical care through use of this system, and another with a continuing chronic respiratory condition has a new outlook on life because of the security this system gives her.

Another new program, "The Generation Connection," initiated by the Baltimore Jewish Big Brother and Big Sister League, has volunteer teams of big and little sisters providing regular friendly visiting to homebound elderly tenants.

As current statistics constantly remind us, the proportion of aged vulnerable tenants in apartment buildings, such as those managed by the Campbell Company, will continue to increase in the coming years. The Campbell Company has made an invaluable contribution to improving the lives of the elderly by testing a service strategy that can serve as a prototype for other collaborative ventures in congregate apartment buildings across the country.

The Campbell project has demonstrated that combining the expertise of commercial apartment management with the philosophy and skills inherent in human services is one way to realize the goal of enabling older people to live independently and with dignity in their own homes for as long as possible. ■

Janet B. Kurland is Associate Director of the Aged Services Department at Jewish Family Services in Baltimore and Gail E. J. Lipsitz is Administrative Associate for the agency. The authors would like to thank Ann H. Kahan, Barbara Carson and Shana Goldfinger for their assistance with this article.

The name used in the case history in this article is fictitious.

A Voice for the Frail Elderly

Philadelphia advocacy group makes the system work for the ill and the homebound

by Jennifer Alwong

Two older women, Annette Summers and Cora Bowen, place a call to the CARIE LINE, a service of the Coalition of Advocates for the Rights of the Infirm Elderly (CARIE). They are concerned about their neighbor, Mr. Otis Hamilton, an 88-year-old man who frequently comes to their homes to ask for food. They tell the CARIE LINE social worker that Mr. Hamilton is arthritic and frail, that his condition has deteriorated since his wife died, and that his clothes are generally dirty.

According to the two women, Mr. Hamilton has the income to live comfortably since he is a retired school system employee who receives a pension from the Board of Education and a Social Security check. They say his granddaughter, who lives in the area, has power of attorney, and there are allegations that she is financially exploiting him, in addition to not providing for his care.

The CARIE LINE social worker provides the two neighbors with the number of the Adult Protective Services program, urges them to call for assistance, and promises to follow up on the progress of the case to insure a complete investigation of Mr. Hamilton's predicament.

The call from Mrs. Summers and Mrs. Bowen is typical of the requests for help that come in every day to CARIE's telephone service. But before finding out the part that the CARIE LINE plays in one-to-one advocacy, the reader needs to know what CARIE is and how the organization assists the elderly in the Philadelphia area.

Established in 1977, CARIE is a nonprofit coalition of organizations and individuals that works to protect the rights of the infirm elderly, to promote awareness of their special needs and problems, and to assure that necessary services are made available.

The infirm elderly can rarely advocate for themselves individually, nor can they influence policy collectively. Unlike the "well" elderly, they do not attend rallies, write to legislators, or testify at hearings. In speaking for this group, CARIE divides its advocacy role into three general categories: advocacy for individuals, organized community advocacy, and advocacy involving broad-based systemic change. Each of CARIE's programs relies upon this model in its day-to-day operations.

Advocacy for Individuals

The CARIE LINE that Mr. Hamilton's neighbors contacted is a telephone service that handles complaints, resolves problems, and provides information about how to obtain and appraise services, benefits and entitlements. The CARIE LINE prefers to empower people by providing them with accurate information, and this works well when there is someone calling on behalf of a frail older person.

However, in many cases, the caller needs assistance with each step of advocating, particularly when the caller is a stressed caregiver, an overburdened social worker, a busy doctor, an anonymous neighbor, or a frail older person who is confused or forgetful. Often, the elderly callers simply don't have the energy or patience to make sometimes endless telephone calls, to follow up on referrals, or take whatever type of action may be necessary to advocate on their behalf.

This was the case with a 58-year-old man who recognized that he could no longer cope, by himself, with the burden of caring for his mother, a victim of Alzheimer's disease. The son told the CARIE social worker that he had quit his job as a professional writer 10 years before to care for his mother because his father was an alcoholic who was neglecting his wife and the deteriorating family home. The son explained that over the years he had tried to make some repairs in the house and had depleted his savings in supporting himself, his mother, and his father who recently died.

Exhausted by the stress of round-the-clock care of his mother, the son contacted a local guidance program to request in-home services, but the program's social worker ended up recommending nursing home placement for his mother because of the delapidated condition of the house. The son told the CARIE social worker that he strongly disagreed with the recommendation because he felt that he could continue to provide very good care for his mother at home.

The CARIE social worker visited the home and found that although it was in need of major repairs, it was clean and that the mother was well cared for by the son. CARIE was able to intervene on the son's behalf and to work with the guidance pro-

The CARIE LINE handles complaints, resolves problems, and provides information about how to obtain services, benefits, and entitlements.

Mae Paetow (left) gets advice from CARIE LINE staff member Liz Jayes.

gram's caseworker to arrange for in-home services and a home repair grant, which enabled the son to continue caring for his mother. Sometimes, another viewpoint is needed, and in this case, it was CARIE's intervention that resulted in the development of an effective service plan.

This type of individual advocacy is also available to nursing home residents. CARIE currently contracts with the local Area Agency on Aging, the Philadelphia Corporation for Aging, to provide long-term care ombudsman services in 26 nursing homes in Philadelphia. The program, mandated by the Older Americans Act, focuses on resolving problems of nursing home residents and their families and friends, problems concerning quality of care or administrative issues.

One recent case provides a good example of the way the program operates. Mrs. Keene had been recuperating from a hip operation in a nursing home for three weeks, when her daughter Jane discovered an area of redness and inflammation. Jane decided to contact the Nursing Home Ombudsman at CARIE for assistance in remedying the problem.

After meeting with Mrs. Keene and Jane, the Ombudsman set up an appointment to meet with the Director of Nursing, the Administrator, and Jane. During this meeting, they developed a plan to treat the skin breakdown, including dressing changes, regular turning, and a special mattress. Since individual attention to patient problems varies, CARIE's Ombudsman advocates to ensure that residents receive the care that they need.

Within the Ombudsman Program, CARIE sponsors a volunteer visitation program which focuses on alleviating isolation and loneliness of nursing home residents. The program recruits and trains volunteers of all ages and matches each volunteer with a resident who has no regular visitors. Training includes informa-

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tion about the aging process, problems facing nursing home residents, interpersonal communication, and advocacy skills. The Coordinator of Volunteers provides on-going support and in-service training to volunteers.

Community Advocacy

In addition to individual advocacy, CARIE's staff and volunteers are regularly involved in community or group advocacy. To illustrate this, it is best to take a look at CARIE's three major committees: the Legislative Commitee, the Community/In-Home Services Committee, and the Nursing Home Committee. These committees, which meet monthly and include representatives from numerous agencies, provide a unique opportunity for professionals and consumers to work together on long-term care issues.

The members identify service needs and gaps, sharing information necessary to develop new service programs and advocacy initiatives. The committees monitor legislation, develop educational materials, and organize and provide training programs, seminars and workshops. For example, the Nursing Home Committee has sponsored several workshop series for activities directors and social workers in nursing homes on such topics as patient rights and dealing with dementias.

CARIE's quarterly newsletter, weekly radio show on issues affecting senior citizens, and Speaker's Bureau are just a few of the methods employed to alert the general public to problems faced by the infirm elderly. Each year, CARIE also sponsors Nursing Home Residents' Week in April, an event focused on increasing the community's awareness of, and involvement in, nursing homes.

CARIE also sponsors an annual meeting in October, an issue-oriented conference that is widely recognized by the professional community. The 1983 annual meeting, which focused on elder abuse, resulted in the organization of the CARIE-sponsored Philadelphia Elder Abuse Task Force. This Task Force now has 60 members representing over 40 legal and social service agencies and institutions in the Philadelphia area.

System-wide Advocacy

The third component of CARIE's advocacy role involves system-wide advocacy concerning policy change. Participants in this advocacy role include CARIE's staff, volunteers, individual and organizational members, newsletter subscribers, radio show listeners—anyone who comes into contact with CARIE and who feels compelled to do something to make a change.

For over a year, CARIE has been involved in advocating for additional funding for the In-Home Service Program in Pennsylvania, which is primarily supported by the State lottery. Due to the burgeoning older population and funding limitations, the waiting list for in-home services in the Philadelphia area is getting longer every day. When CARIE promotes awareness of the need for in-home services or of other problems confronting the vulnerable elderly, the public responds; people write letters to elected officials, testify at hearings, and meet with policy planners.

The three-component advocacy model which is employed to fulfill CARIE's mission is unusual yet highly effective. The three elements—advocacy for individuals, community advocacy, and advocacy for policy change—are interdependent and work cooperatively: the response to the in-home service crisis provides a good illustration of this interdependence.

CARIE first became aware of the problem through repeated complaints on the CARIE LINE. CARIE LINE staff brought it to the attention of the Community/In-Home Services Committee, and several members of the Committee shared similar experiences. The Community/In-Home Services Committee formed an *ad hoc* committee which proceeded to carry out steps aimed at policy change.

The various advocacy roles in the CARIE model are reliant upon one another and are set up to prompt effective action on behalf of the frail elderly—a vulnerable and virtually silent group.

For further information, contact: CARIE, 1315 Walnut St., Suite 1310, Philadelphia, Pa. 19107 (215) 545-5728. ■

Jennifer Alwang was formerly coordinator of the CARIE LINE and is now Regional Coordinator for the CARIE-Sponsored Pennsylvania Elder Abuse Prevention Project.

The names used in the case histories in this article are fictitious.

A Bridge Between Hospital and Home

Patients recuperate in a new type of facility

by Lou Anne Poppleton and Reba Cornman

Meridian Home Health Services in Baltimore, Maryland has set up "Halfway to Health," a residence staffed by a graduate social worker and a 24-hour personal care aide, to provide a place for older people discharged from the hospital to regain their strength before going home.

The residence, which consists of several large adjoining apartments, is partially funded by a $50,000 Administration on Aging grant awarded to the State of Maryland Office on Aging to demonstrate public-private sector cooperation in meeting the needs of the elderly.

Meridian Home Health Services recognized that there was a gap in care for many older adults who did not need to be in a hospital or a nursing home but who did need some health care supervision. It was for this older population group that Meridian Home Health designed the Halfway To Health housing program.

The program was a natural step in the development of a continuum of long-term care services by Meridian Home Health's parent organization, Meridian Healthcare. Based in Towson, Maryland, Meridian Healthcare operates 25 nursing homes in 4 states. But the organization also believes in offering clients other options, such as home health services and "Elderman-age"—a full range of in-home services to promote independent living.

The new Halfway to Health apartments are designed for 4 to 6 people 65 years of age and older who are leaving the hospital or a nursing home but who continue to need help and encouragement in accomplishing the activities of daily living.

Managing the day on their own helps in the recuperation process

Two ground-level apartments, joined by a public hallway and a telephone communication system were rented and furnished in a suburb of Baltimore. They are staffed by the part-time Project Manager who is an MSW and a live-in homemaker/home health aide.

The Project Manager oversees the operation of the apartments and is the liaison with referring hospitals and nursing homes. She meets with and assesses the eligibility of the individuals referred to the program and arranges for the services which might be needed when the individual returns home. The homemaker/home health aide does the cooking, cleaning, laundry and shopping and assists those residents who need help with bathing and dressing.

If intermittent skilled services (nursing or physical, occupational or speech therapies) are needed, referrals are made to Meridian Home Health Services, and the residents are seen at the housing site. (These skilled visits may be reimbursed by Medicare or other insurance resources.)

The apartments were chosen for their accessibility. They are both large 2-bedroom apartments, each with two bathrooms that are completely outfitted with safety bars. Three of the four bedrooms are semi-private, and the fourth is for the live-in homemaker or her relief person. There is a communal dining area, a living room with a TV, and a second living room area for reading, private time and family visits. Both apartments have patio areas, and one apartment has a wooden plank walk built to the permanent sidewalk and parking lot area. This allows easy accessibility to transportation and has made walking a safe accomplishment for the residents.

The cost of maintaining the apartments is met by a $14 per diem rate charged to the residents which is matched by $14 in grant funds. At the end of the grant year (February, 1987), it is hoped that a per diem rate can be established which will continue the economic viability of the project without supplemental financial support.

Patients Retain Control

The apartments are furnished and set up to create an unstressful, home-like environment that will encourage the residents to be involved in their own care as they gradually get stronger.

"This place is like home," commented Mrs. Hartke, an 87-year-old woman who came for a 2-week stay following her second hospitalization within a 2-month period. She had suffered a slight stroke, leaving her with double vision, and had more recently been admitted to the hospital for dehydration, nausea and vomiting. "You can do whatever you want and when you want. It really makes you feel good." Mrs. Hartke returned home within two weeks, eating well and feeling much stronger and more confident.

The ability to manage the day on their own, except for communal eating and perhaps assistance in bathing, has become a very important advantage for the residents and has helped in the recuperation process.

The residents also offer each other mutual support and the shared understanding of what it is like when you are ill and leaving the hospital. They help each other to figure out easier ways to do daily routines that they will soon be accomplishing on their own.

For Mr. Kennedy, a 75-year-old man who lives by himself, the program was a welcome solution after he tripped and broke his ankle in his apartment and was hospitalized for two weeks. Mr. Kennedy was especially upset because he visited his wife, a victim of Alzheimer's disease, in a nursing home every day.

When he was ready for hospital discharge, it was very clear to him that he could not manage at home. His adult children lived out of town and could not offer him the kind of ongoing daily care he needed. Even if they had lived nearby, Mr. Kennedy was a very independent man who did not want to impose on his children.

Mr. Kennedy's confidence in himself had been undermined by the fall, and he was fearful that he would never again regain his ability to care for himself and his wife. The stay at Halfway to Health helped him to relax and give himself the time to get better. He received physical therapy at the residence and quickly increased his endurance while walking with crutches.

"It's just a godsend, this place," he said. "For the moment, even this problem (the broken ankle) is gone. This place has opened up everything for me." Mr. Kennedy returned home after three and a half weeks when his cast was removed and he knew he would be able to manage his home tasks and cook for himself.

Professionals Enthusiastic

In the past eight months, Halfway to Health has admitted 9 men and 14 women, who have stayed an average of three and a half weeks. Their medical conditions have included vertebral fractures, emphysema, cardiac problems and recovery from surgery. The oldest resident, who was 92, received outpatient surgery and stayed one week. The youngest resident was 64.

The time at the residence seems initially to be involved with rest and regaining a sense of one's personal and physical strength. The fatigue of illness, depression and worry about the ability to regain a level of independence that will allow a return home is the shared concern of all the residents when they arrive. Many of the individuals have never been ill before, and certainly were never in need of any kind of elaborate arrangement for their own care.

This short-term intervention has helped to prepare older people leaving the hospital or a nursing facility to resume independent lives in the best possible environment—their own homes.

For more information, contact Lou Anne Poppleton, Meridian Home Health Services, 211 East Pleasant St., Baltimore, Md. 21202 (301) 752-1883. ■

Lou Anne Poppleton is the Project Director of the Halfway to Health residence and Reba Cornman is the Project Manager.

The names used in the case histories in this article are fictitious.

Easing the Burden on

New York City Alzheimer's Resource Center offers comprehensive services to caregivers

Mrs. Kate Wiebert, 75, was referred by her daughter to the New York City Alzheimer's Resource Center for counseling. Having spent her married life being cared for, Mrs. Wiebert had become increasingly angry and incapable of caring for her husband now suffering from Alzheimer's disease. Although Jack Wiebert, 82, was still able to manage his daily activities, he had become depressed, confused and agitated. While medication had been prescribed by his physician, Mrs. Wiebert administered it haphazardly.

Counseling was initially conducted for both Mrs. Wiebert and her daughter. As Mrs. Wiebert came to understand that she could benefit from counseling independently, one-on-one sessions were arranged which focused not only on reducing her anger but on reducing her stress. Home care services were provided to give her respite; an accountant was hired to take care of financial matters; and finally, through therapeutic role-playing, Mrs. Wiebert learned to modify her responses and to communicate with her husband in a more compassionate way. Kate Wiebert has since progressed from interventive counseling to a family support group where she reports she enjoys interaction with other caregivers.

Alzheimer's Families

by Leane B. Cheek

Case histories like this one which reflect an emphasis on individual guidance as well as multi-service linkages for family members of Alzheimer's disease patients characterize the efforts of the New York City Alzheimer's Resource Center. Established as the first municipally-supported agency of its kind in the nation, the Center directs 85 percent of its guidance and assistance activities to family caregivers.

As Janet S. Sainer, Commissioner of the New York City Department for the Aging, which administers the Center, reported last July in testimony before the Subcommittee on Aging of the U.S. Senate Committee on Labor and Human Resources:

"The care of people with Alzheimer's disease must include the care of people whose lives are affected by Alzheimer's disease—namely, the families of Alzheimer's victims. Families have taught us how desperately enmeshed they are in the dilemma of increasing demands and decreasing resources: financial, emotional and physical. We have seen first-hand how the progressive deterioration and unpredictability of the disease force the patient and family to adjust continuously to new and higher levels of impairment. With these ever-changing levels come new and diverse needs that must be met."

Working in collaboration with the New York City Chapter of the Alzheimer's Disease and Related Disorders Association (ADRDA), the New York City Alzheimer's Resource Center first opened its doors in March, 1984. It serves today as a central coordinating unit to link Alzheimer's patients, their families and professional care providers with appropriate services and programs citywide. Funded by the City of New York under a special initiative of Mayor Edward I. Koch and the Brookdale Foundation, the Center offers guidance on such matters as referral to appropriate medical diagnostic centers, public benefits and entitlements, and other sources of support.

> ***With AoA funding the Center started a legal and financial planning service for Alzheimer's families.***

Because it is administered by the largest Area Agency on Aging in the country, which is also an arm of municipal government, the Center is able to rely on the Department's 15 years of experience in linking families to community-based services—homecare, adult day care, respite, home-delivered meals, escort services, and friendly visiting. In the past four years, the Center has worked, as well, to identify service gaps and to ascertain how existing systems can be most effectively utilized to meet the specialized demands created by Alzheimer's disease.

The Center recognized early on that Alzheimer's families carry a staggering burden of conflicting emotions. It therefore began to provide free, confidential one-on-one counseling for short-term therapeutic intervention. Conscious, too, of the difficulties involved not only in coming to terms with the prospect of having to place an Alzheimer's patient in a nursing home, but in making an appropriate placement selection, the Center provides expert guidance on these decisions, with post-placement follow-up where necessary.

With funding from the Administration on Aging, the Center recently implemented a legal and financial planning service for Alzheimer's families who cannot otherwise afford private counsel. Working in cooperation with the Hunter-Brookdale Institute on Law and Rights for Older Adults, the Center now provides a professionally trained and supervised core of law interns who offer assistance with power of attorney, estate planning, fair hearings, and negotiating procedures for securing benefits. The Center is now able to help families address numerous issues that pertain to long-term planning for Alzheimer's patients.

Citywide Public Education

Public education has also been a main objective of the New York City Alzheimer's Resource Center. Public understanding of Alzheimer's disease was just beginning to take hold in 1984 through the efforts of the Alzheimer's Disease and Related Disorders Association. Building on these efforts, the Center concentrated on dissemination of information about the disease itself and the Center's availability to provide direct help—especially to family members. In addition to widespread distribution of a Center brochure, media support, which included public service announcements and a special "car card" campaign in subways and buses, was instrumental in reaching Alzheimer's families.

In a short time, the Center began to offer seminars and workshops aimed at specific target audiences—particularly those who are in frequent contact with Alzheimer's patients but do not have enough information about symptoms or where to obtain help. The target groups have included clergymen, housing project staff and precinct police personnel.

From the beginning, the Center has held an Annual Mayoral Conference to raise public awareness and to provide an arena in which family caregivers and professionals can pose questions and make recommendations on how Alzheimer's-related needs can be addressed. These conferences have annually drawn over 1,000 participants from across the city.

Each year's mayoral conference has provided not only a morning plenary session offering expert speakers but 10 concurrent afternoon workshops led by specialists in their fields and focusing on concrete caregiver problems. These have ranged from understanding the medical diagnostic measures that evaluate Alzheimer's patients and financial planning for incapacity to communication with the cognitively impaired and use of the self-help network for caregivers.

3 Books Get Wide Attention

Publications are essential to providing help for those whose lives are affected by Alzheimer's disease. The Center's first book, *Alzheimer's Disease: Where To Go For Help In New York City*, is a directory of current programs and services available to families and professional care providers, and is now in its third edition.

A second publication *Caring: A Family Guide To Managing The Alzheimer's Patient At Home*, presently in use nationwide, is a 109-page, illustrated step-by-step approach to caring for the Alzheimer's patient in the home. The book includes up-to-date information and techniques recommended by medical experts and professional caregivers. Chapter topics include the principles of caregiving and resources for caregivers, creating a safe and manageable home and environment, applicable exercises and movement, and activities to help keep the patient alert. *Caring* has been extremely well received by family members and professional care providers.

Over the years, the New York City Alzheimer's Resource Center has received many inquiries from across the country about replication or adaptation of its service components and publications. The Center continues to respond to inquiries regarding technical assistance in developing special initiatives or services for Alzheimer's programs.

The Center's newest publication, *Agendas for Action: The Aging Network Responds To Alzheimer's Disease*, is, in part, a response to such inquiries. *Agendas for Action* is a comprehensive, 164-page directory and summary of current services offered by State and Area Agencies on Aging in 46 states to Alzheimer's disease patients and their families. Also highlighted are state efforts, with emphasis on task forces and study commissions created to investigate the impact of Alzheimer's disease and to recommend appropriate policy and legislative action. In addition, the directory includes an extensive listing of the wide range of Area Agency on Aging activities. A special section is dedicated to the Administration on Aging's 12 demonstration projects now being funded through its Alzheimer's Disease Initiative.

Publications on Alzheimer's Disease

Available from the New York City Alzheimer's Resource Center, 280 Broadway, New York, N.Y. 10007 Phone: (212) 577-7564

CARING: A Family Guide To Managing The Alzheimer's Patient At Home is designed to give practical information and techniques for day-to-day management of the Alzheimer's patient in the home. Topics range from communicating with the cognitively impaired to keeping the patient alert and active, to creating a manageable home. $10.00; $8 a copy for orders of 5 or more.

AGENDAS FOR ACTION: The Aging Network Responds to Alzheimer's Disease is a newly published 164-page reference book describing Alzheimer's-related services and programs currently available through State and Area Agencies on Aging across the country, plus a description of the scope of the activities of the New York City Alzheimer's Resource Center. $12.00; $9.00 per copy for orders of 5 or more.

ALZHEIMER'S DISEASE: Where To Go For Help In New York City, is an 88-page directory listing up-to-date available resources that include medical diagnostic centers, family support groups, homecare, home-delivered meals programs, and adult day care. $4.00.

As Carol Fraser Fisk, Commissioner of the Administration on Aging, observed in the introductory section of *Agendas for Action*:

"The nation's State and Area Agencies on Aging have earned the heartfelt thanks of many thousands of people for their actions to develop and expand systems of family and community-based care for the victims of Alzheimer's disease. *Agendas for Action: The Aging Network Responds to Alzheimer's Disease* documents not only what we have achieved but also instructs us, through its many examples of innovative programs, that much more can be done."

It is currently estimated that there are from 2.5 to 3 million elderly across the nation who are victims of this disease. With the continuing dramatic increase in the very old, it is expected that the incidence of Alzheimer's disease will also increase.

Role of the Aging Network

Research indicates that most Alzheimer's families keep their relatives at home for 5 to 7 years after the diagnosis has been made. These caregivers need increasing help in managing the patient in the home and in coping with the rigors of what has been so accurately called the "36-hour day." A sadly distinguishing feature of Alzheimer's is that it follows a lengthy course of decline and that its continuum is staggering both in the intensity of care needs and the toll it takes on the family caregiver.

The New York City Alzheimer's Resource Center holds the view that the aging network is in a unique position to respond to the multiple needs of Alzheimer's patients and their families. With 56 State Units and 672 Area Agencies on Aging, the network administers a variety of community-based services, has expertise in entitlements, and has the capacity and ability to link those in need to local community resources and various service systems. It also has an administrative structure in place which can be built upon in a very cost-effective fashion to meet the needs of the Alzheimer's family population.

For more information about the Center, contact Randi Goldstein, Director, New York City Alzheimer's Resource Center, 280 Broadway, New York, N.Y. 10007 (212) 577-7564. ■

Leane Cheek is Associate Director of Public Affairs for the New York City Department for the Aging.

The names used in the case history in this article are fictitious.

"I wash towels I've barely touched because Mother *can* fold towels . . . and she wants to help. So I see that there are always some that need folding."

"Sometimes he calls me by his ex-wife's name . . . I know he can't help it, but it's hard to take. All those years together are just slipping away from his memory."

"My 4-year-old grandson can do puzzles that Mother can't do. He seems to accept her limitations . . . In his childishness, he has a lesson to teach me."

"I learned to ask for help. My sister won't offer but if I ask, she'll come through. I just tell myself I'm doing the best I can do."

Putting Their Caring on the Line

A telephone support network for families caring for Alzheimer's patients

by Catherine Chase Goodman

These are fragments of conversations that travelled across distances bridged by a telephone network, called CARE-LINE. Set up for caregivers to Alzheimer's patients, the telephone support network is a demonstration project funded by the Administration on Aging and sponsored by the Andrus Gerontology Center at the University of Southern California.

The five caregivers in the network talk with one another on the phone in a rotating pattern over a 12-week period. In addition, they listen to short lectures accessed over the telephone which guide the support network and provide specific information about Alzheimer's disease.

Here's how it worked for Helen Snow, an 82-year-old woman caring for her widowed sister who has Alzheimer's. Mrs. Snow was frail herself and had severe arthritis. She continued to care for her sister because "there's no one else to care for her. She and I ran the factory all the time her husband was ill until his

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Catherine Chase Goodman is the Project Director of CARE-LINE at the Andrus Gerontology Center at the University of Southern California and an Associate Professor of Social Work at California State University at Long Beach.

death. Sure it's hard, but I can still manage it."

Mrs. Snow was referred to CARE-LINE through the local senior center and was later interviewed by a member of our staff. She received a *Network Guide*, which contains written instructions and summaries of the phone lectures, and was assigned to a network of four other elderly caregivers (two spouses and two other siblings.)

The first week Mrs. Snow initiated a call and received a call, following the instructions given in a short telephone-accessed lecture. The following week she called a person she hadn't talked with before, and received a call from someone new. The third week, the calling pattern started over and continued subsequently in rotation. These telephone conversations are usually about 15 minutes long and often begin with topics suggested in the phone-accessed lecture on caregiving.

CARE-LINE solves several critical problems for caregivers experiencing a crisis because they are overburdened and overstressed. Often there is no nearby support group and even when there is, finding someone to care for the elderly relative may be hard to arrange. In some cases, the caregiver may be ill and frail and unable to attend. Getting help as a caregiver may also seem just like one more burdensome task to someone who is already exhausted.

The telephone brings a support network right into the home of the caregiver, and calls can be arranged at the convenience of the individuals involved. An important program goal, of course, is to reach caregivers who would otherwise be isolated.

Bringing caregivers together over the telephone is a new development in self-help programs, which operate on the principle that there are untapped strengths in people for helping one another when coping with a common problem.

The network, however, is really very different from the traditional self-help group. Private conversations between two caregivers, instead of with a whole group, appear to speed up the acquaintance process. In a network of five, there are 10 relationships formed. Each participant talks with each other participant six times during the 12 weeks. That's enough time to form a friendship if there's good rapport. We can't expect to always make a match of all five people, but we hope that at least three will hit it off and form relationships that can continue after the end of the program. Several members from our first network are still in touch with each other after four months.

Since the telephone bridges distances and allows access to a wide variety of people, it has become possible to form homogeneous networks. Spouses of Alzheimer's victims are matched with other spouses. Adult children can talk to other adult children. The concerns of caregivers of advanced age, like Mrs. Snow, are different from those of younger men and women who sometimes have young children at home. The similarity between participants makes talking and understanding easier, so trusting relationships form quickly.

Caregivers can "unburden" themselves by talking. One participant commented: "I was more able to be myself than I have been in a long time." Another felt good about offering valuable support: "I was glad I was able to use my experience to help someone else cope with the burden."

The burden comes from watching a loved one slowly lose their mental capacity. Not only do caregivers gradually lose a parent, a spouse, a brother or sister or a friend, they are saddled with round-the-clock concern which often means total care of a dependent adult. Handy hints, difficult situations and family conflicts are often the topic of the conversations that go on over the CARE-LINE. Much useful information is exchanged, and sometimes members have joined forces to screen nursing homes or circulate recent news articles on Alzheimer's disease.

One of the benefits of this kind of program is that it can be easily duplicated in other areas. The taped phone lectures can be played on some types of ordinary answering machines. All a sponsoring agency has to have is an available phone line, a client group of caregivers, and a staff person to coordinate and set up the networks.

The CARE-LINE Project will make available, at cost, the participant's guide and a program manager's guide in December of 1987. A workshop will also be held at that time for individuals and agencies interested in duplicating the project.

The idea of a phone support network has opened the way to programs for other groups as well, such as, the blind, the ill elderly, people with rare disorders who live far apart, and the rural elderly. Telephone support networks can bring new meaning to the phrase, "person to person."

To obtain a factsheet and brochure on the project, contact:

CARE-LINE
Andrus Gerontology Center
University of Southern
California
Los Angeles, Calif. 90089-0191
Phone: (213) 743-6829

The name used in the case history in this article is fictitious.

Getting the Homebound Out of the House

If you are frail or disabled, getting out of the house for a full day of socializing one day a week can be "a godsend," to borrow the expression of one of the elderly participants in Project CHAI in Brooklyn, New York.

"If the program didn't exist, I'd feel abandoned in the house," says Ethel Sokel.

CHAI (Community Help for the Aged and Infirm) is a project of the Brooklyn Section of the National Council of Jewish Women (NCJW) that provides 50 homebound older people with an opportunity for socializing and recreation one day a week in space provided by NCJW.

Commenting recently on Project CHAI, Janet S. Sainer, Commissioner of the New York City Department for the Aging, said, "Programs like these are of great value as they strengthen the support system and enable the frail elderly to continue to be a part of the community."

The participants are all receiving Medicaid-funded home care and skilled nursing services through the demonstration "Nursing Home Without Walls" program of the Metropolitan Jewish Geriatric Center (MJGC) in Brooklyn.

MJGC subcontracted with the Brooklyn Section of the National Council of Jewish Women to establish the CHAI recreation program for the homebound. Under the guidance of a graduate social worker, recreational therapist and an aide, Project CHAI meets three times a week from 10 a.m. to 4 p.m. at the Council Center for Senior Citizens. Each participant comes once a week on his or her scheduled day (about 16 people per day), with transportation by car service and ambulette provided by the Metropolitan Jewish Geriatric Center.

Activities range from art, music and exercise to movies, trips, educational programs and group discussions about isolation, depression and other problems affecting the homebound. The participants also put out a newsletter called *Still Pitching*, an ingenious title that says a lot about the spirit of the program.

Members also enjoy a Library Corner and new books supplied regularly by a visiting librarian from the SAGE Public Library Program in Brooklyn. A wonderful roof garden on top of the Center provides an opportunity for sun and fresh air, pleasures not taken for granted by people who have difficulty getting outdoors.

There's a strong sense of belonging in each of the three groups; phone numbers are exchanged and an informal telephone help-line has been established. Each group has become a sort of "family," with absent and sick members contacted, supported, and encouraged to return.

"This program is the best thing that ever happened to me," says Lillian Daniels. "When you're cooped up in the house the way I am, you look for something else when your nerves hit the floor. I have been helped tremendously."

"It's a pleasure to know that somebody cares and one cares for one another, because we are all in the same boat," comments Dorothy Toporek.

"On warm days we go up on the roof. The sun is shining and it's beautiful up there—we even had a little plant project," says James Muck, while Bertha Sena comes right to the point: "I know I have one day a week I enjoy."

Rose Lindenbaum also looks "forward to every Wednesday out, and being with other people. I get up at 5 a.m. to give me enough time to get dressed. We could sleep here," she jokes.

What all of the people at Project CHAI have found out is that communities and the frail elderly don't have to accept the categorization, "homebound," as virtually a medical and unchangeable condition.

For further information, contact:

Patricia Weiss, Chairman
Project CHAI
National Council of Jewish Women
1001 Quentin Rd.
Brooklyn, New York 11223
Phone: (718) 376-8164

An afternoon of socializing at Project CHAI.

News Notes

¡A nuestra salud!

Resources for Hispanic And Other Minorities

The translation of some of the National Institute on Aging's (NIA's) popular *Age Pages* into eight different languages by various groups and the publication of a directory in Spanish of services to the elderly in New York City are among recent efforts to reach out to the minority elderly.

The National Association for the Hispanic Elderly has translated 36 of the *Age Pages* into Spanish, with the topics covered ranging from "What To Do About Flu," "Foot Care for Older People" and "Taking Care of Your Teeth" to "Accidents and the Elderly" and "Aging and Alcohol Abuse." The Association is making 25 of the translations available in a packet, called "A Nuestra Salud," for $5.00, but the price is expected to be adjusted now that 11 additional *Age Pages* have been translated. The packet or bulk orders of individual *Age Pages* may be obtained by writing to: The National Association of Hispanic Elderly, 2727 W. Sixth St., #270, Los Angeles, California 90057 (213) 487-1922.

The Association offers a variety of other publications and materials on the Hispanic elderly, including *Barriers: Service Delivery to the Hispanic Elderly in the U.S.*, an audiovisual which comes in English and Spanish. The brochure on the audiovisual notes that 42 percent of elderly Hispanics in the U.S. are defined as poor or "near poor," and explains that *Barriers* explores some of the reasons for the gap between the "obvious need of the Hispanic elderly for social assistance . . . and their actual use of social services supposedly available to them." To obtain information about the *Barriers* audiovisual and the other materials available from the association (including Spanish Heritage Week Posters), write to the address previously noted.

Six of the *Age Pages*, translated into Spanish, are also available free from the National Institute on Aging, as well as 11 bulletins in the series translated into Chinese. To obtain copies, write to National Institute on Aging, Information Office, 9000 Rockville Pike, Bldg. 31, Room 5-C35, Bethesda, Md. 20892. (202) 496-1752.

The San Francisco Department of Public Health has also translated several of the key *Age Pages* into six different languages: Korean, Chinese, Sioux, Russian, Vietnamese and Tagalog (the language of the Malayan people of the Philippine Islands). Free single copies are available from San Francisco Department of Public Health, 1182 Market St., Rm. 213, San Francisco, Calif. 94102, or by calling (415) 626-1033.

The New York City Department for the Aging has published in Spanish a 128-page guide to city services for the elderly, entitled "Guia de Recursos Para Personas Mayores de la Ciudad de Nueva York." Also recently translated is a brochure summarizing the Department's activities and a flier on the city's Alzheimer's Resource Center. Further information on these publications may be obtained by contacting Marie Baptiste, New York City Department for the Aging, Public Affairs Office, 2 Lafayette St., New York, N.Y. 10007 (212) 577-0846.

The AgeLine Database

Whether your interest in the literature of aging lies in unearthing the latest information on Alzheimer's or in enjoying the satire of Dr. Seuss, a computerized search of the AgeLine bibliographic database can provide you with references on your chosen topic in a matter of minutes.

Indexed by almost 1,700 subject terms, AgeLine provides full bibliographic citations with abstracts for 20,000 documents on middle age and aging. Types of documents cited include journal articles, books and book chapters, reports, government documents, conference papers, and dissertations. In addition, AgeLine contains descriptions of all research projects funded by the Administration on Aging (AOA) from 1976 to 1986, including project title and contact information, funding years and amounts, subject index terms, and a project summary. For the years 1976-1980, research funded by other government agencies is also included.

AgeLine is produced by the American Association of Retired Persons (AARP), through the National Gerontology Resource Center. The database grew out of the SCAN system developed under the auspices of AoA's National Clearinghouse on Aging from 1975 to mid-1982. AgeLine has been solely funded and produced by AARP since Fall 1983 and became available to the public in August 1985 following reformatting and updating of the database. Material cited in AgeLine covers 1978 to the present, with selected earlier citations. Updates are added bimonthly.

and journal literature is current to about 4 months.

Using AgeLine

AgeLine is the only bibliographic database devoted solely to the topic of aging and thus provides a valuable reflection of what has been and is being written about aging and older adults. Its primary focus is on the social, rather than the biomedical, aspects of aging, with emphasis on such topics as family relationships, health care and costs, service provision, the economics of aging, and policy formation. Its prime qualities of speed, thoroughness, and flexibility are best used for such activities as performing literature reviews for grant proposals, compiling reading lists for training sessions, providing documentation to support new legislative initiatives, reviewing outcomes of demonstration programs in other localities, identifying funding interests of private corporations and foundations, and providing information to older adults on health and financial concerns.

Each citation in AgeLine is indexed with subject terms from the *Thesaurus of Aging Terminology*, 3rd edition, recently published by AARP as a revision of the 1977 *National Clearinghouse on Aging Thesaurus*. Terms such as "program description," "directory," "bibliography," "consumer guides," and "personal guides" can help the user pinpoint exactly the type of material desired. Thus a review of programs available for widowed persons could be obtained by searching "program description" with the terms "widowhood." Combining "widowhood" with "personal guides" would yield useful titles on coping strategies and practical advice for the widowed. Because of the flexibility of computerized retrieval, a variety of refinements can be made to a search, such as limiting output only to journal articles, or to publications from the past year, or to a certain group of authors.

Database entries are not limited only to citations from gerontological publications and research documents. Within a search, references may appear from weekly news magazines, health care journals, publications for the "over-50" market, or even an

The 1987 Wellness Year Round Calendar

Now you can begin planning another year of health promotion programs with the new Wellness Year Round Calendar issued by the National Council on the Aging (NCOA). Similar to last year's edition, the 1987 calendar is a display-size (11 x 28") beauty that combines practical information and program and activity ideas with color photographs of older people practicing good health.

1987
Wellness Year Round
Calendar

Developed by NCOA's National Voluntary Organizations for Independent Living for the Aging (NVOILA) with support from the Administration on Aging and Johnson & Johnson, the calendar introduces a new theme each month, such as stopping smoking, managing stress or starting an exercise routine. Facts and resources relating to the topic are presented, along with guidelines for improving health and programming ideas appropriate for groups and individuals. Planners may want to review the 1986 edition of the calendar, also available from NCOA, for additional suggestions.

The 1987 Wellness Year Round Calendar may be purchased from: The National Council on the Aging, Publications Department, 600 Maryland Ave., S.W., West Wing 100, Washington, D.C. 20024. (202) 479-1200. Single copies are $5.95 each and five or more copies are $5.00 each.

airline's magazine. With the cooperation of AoA, final reports and associated materials from all AoA-funded projects are included in AgeLine, as are descriptions of all newly funded projects.

Accessing AgeLine

AgeLine is not accessed directly from AARP but by subscription to the search service BRS Information Technologies, which offers its subscribers access to over 100 databases on a variety of topics. Many academic and state libraries maintain BRS subscriptions and will perform searches for individuals at a prearranged fee. Some agencies and individuals prefer to subscribe to one of BRS's user-friendly searching plans and search directly from their offices or homes. These users pay a one-time $75 password fee and are then billed on an hourly basis for usage and telecommunications charges, plus print charges. An average search on AgeLine might run about $20, with wide cost variation depending on search length and complexity. Searching AgeLine on BRS requires a microcomputer or a "dumb" terminal, a modem, a telecommunications software package, and an optional printer.

To receive an AgeLine brochure or to order the *Thesaurus* ($5.00 prepaid, checks payable to AARP), write: AgeLine Database, AARP Resource Center, 1909 K St. NW, Washington, DC 20049. For more information on BRS subscriptions, call BRS toll-free at 800/345-4BRS (in New York call 518/783-1161) or write: BRS Information Technologies, 1200 Route 7, Latham, NY 12110.

(This article was written by Margaret Eccles, the AgeLine Database Manager.)

"Buy Native American" Catalog To Benefit Indian Elderly

The silver and black seed pot looks like a magical sphere the gods have left behind, while a black bear figurine draws his power from the dark, secret forest. In a poster, an ancient Indian woman encircles and guards her exquisitely designed pottery—a symbol of the undying beauty of her culture.

These are among the art objects displayed in a catalog of Native American arts and crafts, which was funded by the Administration on Aging (AoA) and the Administration on Native Americans. The "Buy Native American" Catalog was developed by the AoA-funded National Indian Council on Aging in Albuquerque, New Mexico and Phoenix Systems, Inc., a national marketing company in Sioux Falls, South Dakota.

The catalog, which displays the works of 20 Indian artists, is part of a project designed to demonstrate ways that federal grant dollars can be used to help a nonprofit advocacy organization for Indian and Native American elders to become self-sufficient.

For a copy of the "Buy Native American" Catalog, send $2.00 to the National Indian Council on Aging, P.O. Box 2088, Albuquerque, N.M. 87103.

Aging America Campaign To Publicize The Aging Network

AoA has funded a national media campaign, called *Aging America*, to increase the visibility and knowledge of the older Americans Act network among three groups who have an impact on policies and services for older Americans—health professionals, the business community and public officials. The campaign is being conducted by the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (NAAAA).

The centerpiece of the campaign is a media kit designed for use by state and area agencies on aging in educating the three groups about the aging population and the roles they can play in improving services to the elderly.

The information in the media kit is based on a survey conducted among Area Agencies on Aging (AAA's) and State Units on Aging (SUA's) to determine misperceptions of their role by the public and professional groups and the types of information these agencies would like to convey. Although the Older Americans Act network has been formally in existence for over 20 years, a significant number of State and Area Agencies reported a general lack of awareness of their existence or, at best, confusing ideas about their mission and role.

The media kit includes three black and white advertisements targeted to health professionals, public officials and the business community, giving examples of how AAA's and SUA's can be of service to these groups, and vice versa, in dealing with an aging population. The advertisements, which carry the *Aging America* logo, are intended for journals and publications which regularly reach the three key audiences. The ads list NASUA and NAAAA as a contact point, but SUA's and local AAA's are encouraged to superimpose their own addresses.

Sample fact sheets and press releases in the kit, also targeted to each of the groups, contain demographic data on the elderly and specific ideas for cooperative ventures with agencies on aging. Some of the examples given were: training for physicians in the array of community-based services for the elderly; similar training for utility company and other personnel who are likely to spot signs of distress in older consumers; and use by chambers of commerce of data from SUA's and AAA's to determine the impact of an aging population on business and community services.

In addition, the kit contains a general information brochure on the network on aging, with references to the three target groups. *Aging America* logos are also supplied to reinforce the campaign's identity and to build a growing public awareness of the nation's stake in planning for an aging society.

NASUA and NAAAA officials said that while "the media kit may not create overnight awareness of aging agencies, dispel long-standing misconceptions, or result in immediate offers of collaboration, the initiative is intended to focus more public and private sector attention on the network."

For more information, contact Ed Sheehy, National Association of Area Agencies on Aging, Suite 208 West 600 Maryland Ave., S.W., Wash., D.C. 20024 (202) 484-7520.

AARP Caregiver Pubs For Employers, Local Groups and Individuals

The American Association of Retired Persons (AARP) has developed materials and programs which support family caregivers that can be used by businesses, community organizations, and individuals.

Caregivers in the Workplace is a 4-part program that can be used by businesses and corporations to assist employees who are experiencing the stress of caring for an elderly relative. The materials in each component

New AoA-Funded Report

Adaptive Reuse for Elderly Housing

This is a report that all individuals and organizations concerned with providing housing for the elderly ought to have, including state and local government officials, developers and architects, agencies on aging, churches and other nonprofit groups. Funded by AoA and published by the U.S. Conference of Mayors, the 90-page guidebook covers from A to Z the process of renovating old buildings to provide housing for the elderly as well as space for senior centers, meal sites, and one-stop shopping for senior services.

Issues addressed include architectural design, historic preservation, support services and financing. This last topic is examined in a detailed chapter on sources of federal, state and local funding that even goes into changes in the Tax Reform Act of 1986 that will affect adaptive reuse of old buildings for housing for seniors.

The guidebook includes over 50 descriptions of successful projects in cities across the country—renovation of trolley barns, schools, hotels, hospitals, shopping centers, industrial mills and YWCAs.

As a follow-up to the report, a National Conference on Elderly Housing, sponsored by AoA, the Department of Housing and Urban Development and the Conference of Mayors will be held March 19-20 in Washington, D.C. To find out about the conference, contact Larry McNickle at the U.S. Conference of Mayors (202) 293-7330.

To obtain a copy of the report, *Adaptive Reuse for Elderly Housing*, send $12.00, plus $2.00 postage to: U.S. Conference of Mayors, 1620 Eye St., N.W., Washington, D.C. 20006.

A more detailed discussion of the report and the benefits of putting old structures to new uses in serving the elderly will be featured in the next issue of *Aging* magazine.

may be used separately, allowing companies to tailor the program to their particular needs.

The first part of the program is a *Caregivers Survey* designed to assess the prevalence of caregiving responsibility among workers and identify areas of stress. The second part of the program includes guidelines for organizing a lunchtime *Caregivers Fair* to which local agencies are invited to provide information about caregiving and services to the elderly. The third component is a *Training Package* for company staff on conducting 10 different 1-hour workshops on issues of concern to caregivers. The package includes resource materials for each workshop. The final component is a *Care Management Guide* for employee counselors to use in identifying caregiver problems employees are experiencing, the services they need, and the organizations that provide services.

Although *The Caregivers in the Workplace* program has been tested at eight companies, ranging in size from 500 to 10,000 employees, AARP has not yet established final prices for the various guides and publications. For further information, contact Angela Heath, Social Outreach and Support, Program Department, AARP, 1909 K St., N.W., Washington, D.C. 20049 (202) 728-4370.

In addition to materials for business, AARP has developed a kit of guidelines and resources to help community organizations organize 1-day workshops for adults who are (or expect to be) primary caregivers for an aging parent. Entitled *Hand in Hand: Learning From and Caring for Older Parents*, the kit includes a Planning Guide which describes the steps necessary to plan and conduct a workshop, a Resource Manual which provides ideas for workshop content, an annotated bibliography, and a program binder.

Hand in Hand can be obtained from AARP Books, Scott, Foresman & Co., Department HHB, 400 S. Edward St., Mount Prospect, IL 60065 for $16 per kit.

To assist individual caregivers, AARP Books is offering *Caregiving: Helping an Aging Loved One* by Jo Horne. The handbook is divided into four parts (1) *Should You Become a Caregiver?* which discusses the need of getting to know the person who needs care; (2) *Getting Started* which discusses living arrangements, getting help from others, financial and legal matter, and setting the ground rules; (3) *Meeting the Care Recipient's Needs* which is about basic nursing techniques and emergency first aid, understanding physical and mental incapacities, and caring for the mentally impaired; and (4) *Meeting the Caregiver's Needs* which explains how to deal with difficult feelings, getting support and finding respite, and working for better conditions. Throughout the book resources are listed that are intended to make the job of caregiving easier and more effective.

Caregiving: Helping an Aging Loved One can be obtained from AARP Books, Scott, Foresman & Co., 400 S. Edward St., Mount Prospect, IL 60056. $13.95 (AARP members—$9.95) plus $1.75 shipping and handling.

In addition, the reader may wish to contact Social Outreach and Support Section, Program Department, AARP, 1909 K Street, N.W., Washington, D.C. 20049 for a free copy of *Miles Away and Still Caring: A guide for Long Distance Caregivers*. This publication is designed to assist caregivers with relatives in a distant city or state.

USDA Bulletins Tell Americans How To Apply The Dietary Guidelines

The Department of Agriculture (USDA) has published *Dietary Guidelines and Your Diet*, a series of 14 bulletins to help Americans understand and apply the dietary guidelines USDA issued in 1980.

Each of the first seven bulletins in the series focuses on one of the basic guidelines. They are: (1) eat a variety of foods; (2) maintain a desirable weight; (3) avoid too much fat, saturated fat, and cholesterol; (4) eat foods with adequate starch and fiber; (5) avoid too much sugar; (6) avoid too much sodium; and (7) if you drink alcoholic beverages, do so in moderation.

The seven bulletins contain nutrition information; suggestions on implementing the guidelines in menu planning; recipes that follow all of the guidelines; and a self-assessment activity to involve readers with the information and encourage them to apply it to their own diet. An introduction to each bulletin reminds readers that, although the bulletin provides in-depth information on *one* guideline, *all* of the guidelines should be considered in selecting a healthful diet.

The second set of seven bulletins in the series, expected to be available later in 1987, will cover the following topics: food shopping, menu planning, food preparation, eating out, bag lunches, desserts and snacks, and quick meals.

The first set of bulletins in *Dietary Guidelines and Your Diet* is available from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402. Include a payment of $4.50 and request stock number 001-000-04467-2. There is a 25% discount on orders of 100 or more.

State and Community News

Helen Nacinck tutors Amy Thoma.

Helping Kids: The Ripple Effect

Senior citizens in Monroe, Michigan who are now involved in helping delinquent teenagers and foster children, began their project in the fall of 1980 with a small tutoring program in an elementary school.

At that time, the staff of the Senior Adult Education Program had added a new class, called *Helping Kids*, to the high school completion curriculum for older adults. The class was designed to provide older adult students with an opportunity to tutor elementary school children in basic math and reading skills. In exchange the older adults could receive credit toward their high school diplomas and could count their time as volunteer hours for the local Retired Senior Volunteer Program (RSVP).

During the next five years, the tutoring program grew from an effort involving 9 seniors tutoring 36 children in one school to a corps of 30 tutors working with 90 children weekly in five schools. (See *Aging*, "Senior Tutors Help the Public Schools," No. 346, June-July 1984.)

As the tutors gained confidence in their skills and ability to build rewarding relationships with children, the "Helping Kids" class began to discuss other ways to assist children and youth in the community. The seniors proposed offering their services to the Monroe County Youth Center, a detention facility for delinquent teenagers. Although the volunteers encountered some concern from county officials worried about the seniors' safety, an enthusiastic local judge was able "to cut the red tape," and four tutors were assigned to the Center.

Douglas Redding, superintendent of the Monroe County Youth Center has high praise for the program: "The volunteers have served as excellent role-models; they have helped improve basic educational skills, and above all, they have established positive relationships with our teenagers. They know the volunteers care, a quality frequently lacking in the relationships of delinquents. I strongly recommend a senior adult tutoring program in all facilities for delinquents."

The success of *Helping Kids* continued to inspire everyone involved to seek other opportunities for intergenerational programs. Several tutors volunteered to join the RSVP pilot project, B.A.B.E.S. (Beginning Alcohol/Addiction Basic Education), which has presented entertaining programs, using colorful puppets, to educate 500 preschoolers about misuse of alcohol and drugs.

Another outgrowth of the "Helping Kids" program is a project called JOY (Joining Oldsters and Youth), a joint effort of the Monroe Senior Citizens Center, the Monroe County Department of Social Services, the Foster Parents Association, and RSVP. Every Saturday foster children are brought to the Senior Citizens Center from 10:00 AM to 2:00 PM to enjoy games, conversation, lunch, and field trips with selected RSVP volunteers. The goal of this program is simply to allow for the natural development of trust and friendship between the foster children and the older people.

The program has been extended to include children living with parents who are receiving help with parenting problems; children of the professionals who work with the program; grandchildren of the senior volunteers; and the natural children of foster parents. Program organizers say this intermingling of natural and foster children has worked out well, with the children developing strong bonds with one another and with the senior volunteers.

Monroe, Michigan is demonstrating what James R. Steed, coordinator of the tutoring program calls "the ripple effect" which occurs when older people find out how rewarding it can be to assist children and youth who need a helping hand. "All that we have accomplished so far only suggests that there is a great deal more to do and a great many people who are willing to do it. Central to our projects has been the realization that the benefits are mutual, everyone who participates is rewarded. The ripple effect begins when one child's smile drops into one giving heart."

For more information, contact James R. Steed, Senior Adult Education Program, 502 W. Elm Ave., Monroe, Michigan 48161. (313) 243-5030.

Senior Center Becomes Medical Satellite To Hospital in Pittsburgh

Building on a clinic established in 1976 and staffed by a nurse practitioner, Vintage Senior Adult Center in Pittsburgh, Pa. has graduated to become a medical satellite to nearby West Penn Hospital.

Vintage's Executive Director Arlene Snyder believes that the senior center may become the "lynchpin" of community-based health care programs for the elderly in the future.

"The growth of the older population, especially the 75-plus age group, sets up conditions that require other than traditional medical treatment," says Mrs. Snyder. "The senior center can stress prevention, education and monitoring of chronic illness and improve the referral route for the older adult."

In 1976, Vintage Senior Adult Center conducted a survey of its 700 participants which revealed many unmet health needs. The most glaring was that only 11% of the females had gynecological care after age 45, but other needs included routine physical exams, blood pressure screening and health education.

The dilemma at the time, notes Mrs. Snyder, was to provide the needed health care without a large staff and an unrealistic budget. The solution Vintage arrived at was to hire a nurse practitioner who would operate a clinic one day a week and offer a wellness oriented health program.

In 1977, with an eye to expansion, Vintage searched for a physician who could serve as a consultant and backup to the nurse practitioner. The clinic was fortunate in finding Dr. C. Reginald Wilson, Chairman of the Department of Medicine at West Penn Hospital, who agreed to offer his services free of charge.

After Vintage opened an adult day care program in 1981, the Center expanded to offer additional health services to a more frail elderly population. With the help of Dr. Wilson, the clinic was able to obtain these and other needed services by establishing a formal partnership with West Penn Hospital which resulted in 1983 in the West Penn/Vintage Geriatric Care Program.

The program is directed by the nurse practitioner and a staff of 15 volunteer nurses and clerical assistants. It offers a full spectrum of care, which includes referral to hospital and medical resources. The services provided at the Vintage clinic include:

- Physical, gynecological and rectal exams, and gross hearing, vision, urinalysis, and hemoglobin testing. Each assessment includes a health care plan and follow-up by the Vintage nurse practitioner.
- Podiatry.
- Health care monitoring by the Vintage Nurse Practitioner working in cooperation with the person's physician.
- Individual and group education, counseling and wellness programs.
- Physician consultation for Vintage professionals at client case conferences at the Vintage clinic.

In addition to the clinic services, free community health screenings are provided on site. They include blood pressure, glaucoma, audiology, dental, dermatology, breast and colorectal screenings, and flu inoculations. These free screenings, explains Agnes Buchanan, the Vintage Nurse Practitioner, have been designed to include a patient history, examination, care plan and follow-up.

For the services provided by the clinic, third party reimbursement is pursued, when appropriate. Patients without insurance are assessed on an individual basis and charged accordingly. No one, however, is denied care.

The clinic, Mrs. Buchanan stresses, "provides a non-threatening environment for the older adult to receive evaluation, education, and referral."

Through the program, each adult day care participant also receives an initial and annual multi-disciplinary physical examination at the West Penn Hospital medical clinic and follow-up for the patient and family by the Vintage nurse practitioner. This approach, says Mrs. Snyder, has improved the quality of the care given by the adult day care nurses.

By 1984, the West Penn/Vintage Geriatric Care Program had expanded the clinic to three days a week and was serving 2,000 persons. About 80% of the seniors using the program came to the nurse practitioner for a routine physical exam, which according to Mrs. Snyder, provides concrete evidence of a productive health and wellness program. "Typically the seniors coming to the clinic," notes Mrs. Snyder, "are cost conscious, tend to minimize all but acute illnesses, are unknowledgeable about their bodies and medications, and are easily intimidated by the health care system."

Mrs. Buchanan reports that among those who came in without an initial complaint, the clinic identified problems ranging from abnormal pap smears to other serious gynecological problems to cardiovascular disease and cancer. "The older adult is often reticent to seek physician care unless forced to do so in an emergency, but because of our wellness/prevention marketing efforts, they do come to the clinic."

A senior gets a physical exam at the Vintage clinic. Photo: Walter Eiseman

Mrs. Snyder stresses that another advantage to locating a health program within a senior center is that both the emotional and physical wellbeing of the senior adult can be addressed through an integrated network of social programs and health resources. The Vintage Senior Adult Center has contacts with the Allegheny Area Agency on Aging to provide information and referral; social, recreation and counseling services; congregate and home-delivered meals; and adult day care.

Mrs. Snyder cites several reasons for West Penn Hospital's motivation in forming a partnership with a senior center, including a desire to provide ongoing quality care at a time of restricted hospital utilization policies and the need to improve geriatric education for resident physicians.

"The Vintage/West Penn program", she concludes, "is the type of community-based facility that should be available for assessing and channelling the older client."

(This article is based on interviews with Arlene Snyder and Agnes Buchanan and on a longer paper that they co-authored with Michael Rose, Vice President for Ambulatory Care for West Penn Hospital. For copies of the original article or for further information, contact: The West Penn/Vintage Geriatric Care Program, 401 North Highland Ave., Pittsburgh, Pa. 15206 (412) 361-5003.)

An AAA, Bell Tel and United Way Set Up 24-Hour I & R System

Northwestern Missouri has developed a computerized information and referral system for the elderly that not only serves the city of St. Joseph but 9,254 square miles of predominantly rural towns.

Called *Senior 24*, the 24-hour I & R program was developed in January of 1985 by Southwestern Bell Telephone Company, the Northwest Missouri Area Agency on Aging (AAA) and United Way of Greater St. Joseph.

"The overriding issue when we started," says AAA Director Ron Rauch, was "how could we set up an economical system to assure that I & R services would be accessible to an elderly population of 59,000-plus scattered over an 18-county rural area. We also wanted to make the service available more than just from 8 a.m. to 5 p.m., 5 days a week."

When Rauch learned that Southwestern Bell was also exploring the feasibility of a senior information line, he arranged a meeting with their staff, and a 14-member task force was formed to organize an I & R program. The task force included representatives of the United Way, Family Guidance, the American Association of Retired Persons, Interfaith Community Services, and the State of Missouri Division on Aging.

"At first," recalls Rauch, "it was hard to find a lead agency because of turf problems, but the selection of United Way to operate the system turned out to be the ideal solution."

An anonymous donor gave United Way a computer, and Southwestern Bell provided $7,000 in start-up funds, plus the services of a computer programmer who developed a software program called AIRS (Automated Information and Referral System).

The program enters comprehensive data about the elderly person needing help and then brings up on the screen the community agencies that can provide the appropriate service or assistance. AIRS also has the capability of referral tracking and follow-up.

The Northwest Missouri Area Agency on Aging provides funds for the toll-free number serving areas outside of St. Joseph, 1-800-442-1986. The number in St. Joseph is (816) 364-1131. United Way staff operates the system during weekdays, and volunteers are trained and paid a small stipend to take calls at night and on weekends. Nighttime or weekend callers with serious problems are immediately referred to agency staff who handle emergencies, while non-emergency inquiries are held over until normal working hours.

The *Senior 24* hotline is widely publicized through donated advertising in local newspapers in the 18-county area; radio announcements; TV and newspaper stories on interesting cases handled by the I & R staff; and bulletins posted in laundromats, doctors' offices and agencies serving the elderly.

One emergency call, reports Rauch, came from a traveler who remembered the advertisements for the *Senior 24* hotline when he saw an elderly woman wandering around on the interstate highway.

Publicity on the information line also appears to be effective in reaching the rural elderly. "I was a little concerned that the rural areas wouldn't use the I & R system, but I see from recent reports that we are getting calls from many outlying areas. About 300 calls a month are coming in on the 800 number. And we are also getting a lot of out-of-state callers who want us to check in on their aunts, uncles or grandmothers."

The *Senior 24* coordinating board "is rapidly moving toward a case management approach to help people who either do not qualify for community programs or who present problems not readily handled by existing services," says Rauch. "The information from the data base will also be invaluable in planning future programs for the elderly." "*Senior 24*," concludes Rauch, "shows what can happen when public and private agencies are sincere about coordinating their resources."

For further information, contact Ron Rauch, Executive Director, Northwest Missouri Area Agency on Aging, P.O. Drawer G., Albany, Mo 64402 (816) 726-3800.

Baltimore County Is Proud of Electronic Bulletin Board

News in the network on aging of new services, changes in programs, workshops and training opportunities travels fast in Baltimore County—via the Electronic Bulletin Board.

Baltimore County, Maryland added the electronic "newsletter" to its existing computerized client tracking and case management system which links seven service providers—the Departments of Aging, Health and Social Services, two major hospitals, Meals on Wheels, and Maryland Children and Family Services.

These agencies can now notify one another continuously of any significant information whether it's available home medical equipment in the "Loan Closet," changing eligibility requirements for public benefit programs, or an upcoming workshop on running caregiver support groups.

A menu lists the topics of news bulletins recently entered into the system. Users can then access a bulletin of particular interest, which may contain up to three pages of information, allowing for detailed explanations of programs or service changes. Information sent to the Bulletin Board is put into the system within 24 hours, guaranteeing that the agencies will receive the latest news of developments in the service network.

To learn more about the Electronic Bulletin Board, which received an award from the National Association of Counties last year, contact: Ellen Yerman, Director, Network Services, Baltimore County Department of Aging, 611 Central Ave., Towson, Md., 21204 (301) 494-4201.

A Meals On Wheels Program Adds Liquid Nutrient Supplements

Liquid nutrient supplements, which are generally used in institutional settings, have been successfully introduced in the home-delivered meals program operated by Somerville-Cambridge Elder Services in Somerville, Massachusetts.

"The need for these supplements in Meals on Wheels is emerging due to the increasing number of frail elders who are being assisted in maintaining themselves in their own homes," notes Alan L. Balsam, Director of Nutrition for Somerville-Cambridge Elder Services, which is the local Area Agency on Aging. Also contributing to the need for supplements, says Balsam, are the special nutritional needs of older people discharged from the hospital.

Liquid nutrient supplements are appropriate for people who are chronically underweight, are lacking in teeth or have difficulty in swallowing. Balsam points out that for the frail elderly living at home, "these problems are often complicated by isolation and difficulty in buying and preparing food." The supplements, he notes, are easy to prepare and have a long shelf life.

Case managers at Somerville-Cambridge Elder Services, whose responsibilities include screening clients for home-delivered meals, refer recipients considered to be at risk of poor nutrition to the Nutrient Supplement Program. The referral is reviewed by the nutritionist who indicates the appropriate type of supplement and stresses to the client that the supplement is to be used in addition to, and not as a substitute for, the home-delivered meal.

The supplement is then delivered by the case to the elderly client through the existing home-delivery system for conventional meals, an arrangement that results in little additional time or expense. Participants are asked to contribute, based on a sliding fee scale, to the cost of the supplements. The savings from ordering the supplements in quantity, rather than purchasing them retail, are passed on to the Meals on Wheels participants.

Balsam says that some of the factors that should be considered in selecting supplements for home-delivered meals programs are cost (lactose-based products are often half as costly as soy-based ones); shelf life, taste acceptability and flavors offered, and eligibility for commodity rebate. Balsam explains that all federally funded nutrition programs for the elderly are eligible for partial rebates or discounts when purchasing supplements which include government commodity non-fat dry milk. He cautions, however, that preparations containing lactose are not suitable for elderly people with a low milk tolerance.

Balsam believes that as the number of frail elderly remaining in their own homes increases, meals programs should be encouraged to view liquid nutrient supplements as an important adjunct to conventional home-delivered meals.

For further information or for a copy of a longer article on use of liquid nutrient supplements, including a chart comparing the nutritional value of four popular supplements, contact: Alan L. Balsam, Director of Nutrition, Somerville-Cambridge Elder Services, One Davis Square, Somerville, Mass 02144 (617) 628-2601.

Nassau County Puts Services on the Road

What has four wheels and flyers? What comes to communities where older people live with advice on Medicare, job opportunities, pets for adoption, tax relief? What is bilingual, has a shiny coat of white paint with a bright blue and orange stripe that spells HELP to senior Citizens of Nassau County? It's the Seniormobile—one of the Nassau County (N.Y.) Department of Senior Citizen Affairs' most innovative efforts to improve the quality of life for its senior citizens.

The Department's Commissioner, Adelaide Attard, describes the Seniormobile as a "self-contained traveling information office which brings professionally trained staff of the Nassau County Department of Senior Citizen Affairs right into the neighborhoods where seniors live." "We provide many other in-home and close-to-home services such as home-delivered meals and books," says Commissioner Attard. "Why not *services* on wheels?"

The comfortably furnished, air-conditioned and heated Seniormobile was custom designed with older people in mind, with such considerations as adjustable steps at each of the two doors for easy on-off access. There is a private consultation area where seniors can discuss their concerns. Funds for the vehicle come from the New York State Office for the Aging and Nassau County.

Visiting seniors find specialists on board the Seniormobile who can assist them with Social Security and SSI, tax relief, legal services, passes and discounts, Medicare and Medicaid, complaints, and consumer and other problems. A Spanish-speaking social worker provides assistance to elderly members of the Hispanic community.

The Seniormobile's itinerary is planned three months in advance, and the schedule includes at least two stops in most communities during the year. Locations of high visibility such as shopping centers, libraries, and senior centers are targeted so that seniors can take advantage of the Seniormobile's services. Those who lack transportation to and from the Seniormobile may request free taxi service from companies affiliated with the Long Island Taxi and Transportation Operator's Association.

The Seniormobile carries with it a staff of professionals and a wealth of information. The available materials on community services are helpful to not only older persons but to family and friends. Last year, some 5,000 Nassau County residents visited the office on wheels.

In addition to the Seniormobile, the Nassau County Department of Senior Citizen Affairs operates four

A Seniormobile specialist provides information and referral.

community-based offices and funds 20 Senior Community Service Centers.

The Department of Senior Citizens Affairs has provided technical assistance to Area Agencies across the country to replicate its mobile office. Similar projects have proved highly effective in bringing services to seniors, particularly in suburban and rural areas.

For further information, contact the Nassau County Department of Senior Citizen Affairs, 222 Willis Ave., Mineola, N.Y. 11501.

Publications

Home Health Care: A Complete Guide for Patients and Their Families. By Jo-Ann Friedman. W. W. Norton & Co., Inc., 500 5th Ave., N.Y., N.Y. 10110 (212) 354-5500. 1986. 589 pp. Freight, postage, and tax $22.50.

Home Health Care, a guide for professionals, patients, and their families, is filled with practical information on all home care situations from postsurgical recuperation to recovery from stroke to daily living with a chronic illness or disability.

The book covers the gamut of health problems and addresses concerns about nutrition, exercise, sexual activity, medication, dealing with pain and the dying patient. Detailed information is given about home care services and support groups; health insurance, including Medicare, Medicaid, private groups and individual contracts; how to organize and set up the home; the role of the primary care physician; how to locate products and supplies essential to home care; and the role of the home health aide and therapist.

Home Health Care includes a resource directory which lists a wide variety of social organizations, community groups, health associations and government agencies to contact for information and assistance. The National Association of Area Agencies on Aging is listed to help readers locate the Area Agency serving their community. The book also includes tables, checklists, and questionnaires to help the caregiver in assessing the needs of the patient, and tips to facilitate daily living.

The author, Jo-Ann Friedman, a consultant to the health care industry, and formerly Chief of Speech Pathology at Albert Einstein College Hospital, writes from a personal as well as a professional perspective. In 1982 she became a victim of Guillain Barre syndrome, an illness that affects the peripheral nervous system, which required her to spend five months convalescing at home. Her experience convinced her of the benefits of home care, and she became sensitive to the frustrations and difficulties patients and their families encounter in arranging and coordinating that care.

The book includes a foreword by the well-known *New York Times* health columnist, Jane E. Brody.

Guide to Caring for the Mentally Impaired Elderly. AAHA Publications Department, 1050 17th St., N.W., Suite 770, Washington, D.C. 20036. (202) 296-5960. $20 plus $2.70 postage and handling. 134 pp. 1986. Paperback.

The Guide to Caring for the Mentally Impaired Elderly was written by staff at the American Association of Homes for the Aging. They shared resources, conducted research and produced this guide to working with confused older persons. The guide was developed and refined during a series of two-day meetings convened by the Ontario Association of Homes for the Aged.

Topics addressed in the publication include: "The Dilemma of Mental Impairment," "Initiating a Program," "The Resident," "Staff," "Residential Care Planning," "Programs," and "The Physical Environment." A glossary and a list of suggested additional readings are also provided.

Midlife and Older Women: A Resource Directory. Published by The National Coalition on Older Womens Issues (NCOWI), 2401 Virginia Ave., N.W., Washington, D.C 20037. (202) 466-7834. $4 1986. 88 pp.

Included in *Midlife and Older Women* is an alphabetical listing of over 50 organizations working on issues of concern to older women. The publication highlights the background, goals, and/or mission of each organization, its areas of expertise relevant to midlife and older women, and where appropriate, any direct services offered to, or on behalf of, older women.

The directory is divided in three parts. Part I is arranged alphabetically and consists of detailed descriptions of the organizations. Part II, also arranged alphabetically, lists the 50 or so issues with which an organization might be involved, such as care of aged parents, divorce, insurance, minority women, nutrition, and employment. Following each topic are the names of the organizations working on that issue. Part III is a list of federal agencies working in areas that might be of interest to midlife and/or older women.

The directory was published by The National Coalition on Older Women, a national network of organizations and individuals concerned with the problems and needs of midlife and older women.

Singular Paths—Old Men Living Alone. By Robert L. Rubinstein. Columbia University Press, 562 W. 113 St., N.Y., N.Y. 10025. (914) 591-9370. 1986. 288 pp. $30 plus $3 postage and handling.

Singular Paths focuses on single and widowed men, a frequently overlooked group within the senior citizen population. Based on a series of interviews, Robert L. Rubinstein reveals the situations, experiences and feelings of older men living alone. He finds that depression, loneliness and loss are present in many of the men's lives, but his book also includes a great deal of material on positive adaptations to living alone.

The publication explains how older men can find enjoyment in life, using existing resources and opportunities, both personal and social. In addition, *Singular Paths* includes information about social service programs and senior centers and suggests ways for them to involve single and widowed men in programs and activities.

Robert L. Rubinstein serves as Research Anthropologist in the Behavioral Research Department of the Philadelphia Geriatric Center.

Suicide and the Elderly: An Annotated Bibliography and Review. Compiled by Nancy J. Osgood and John L. McIntosh. Greenwood Press, Inc., 88 Post Road West, Box 5007, Westport, CT 06881, (203) $29.95. 1986. 193 pp.

Suicide and the Elderly begins with an overview of the literature on suicide in old age including contributions in statistics, theory, assessment, prevention and ethics, and an examination of future research needs. The introduction notes that "the old . . . have 50 percent higher suicide rates than do the young and represent the highest risk age group for suicide."

The goal of Professors Nancy J. Osgood and John J. McIntosh in compiling this bibliography was to bring together in one source the accumulated knowledge and reference materials regarding suicide among the elderly, particularly the research findings. Their book contains 450 sources in which materials on suicide and the elderly may be found (i.e. bibliographies and index/abstract sources).

The largest portion of the book is devoted to annotations of individual references on suicide and the elderly, organized in three categories—case studies, surveys, and empirical investigations. A demographic appendix drawn from official statistical sources for the U.S. presents tables and graphs of suicide data by age, sex, and race.

Nancy J. Osgood is Assistant Professor of Sociology and Gerontology at the Medical College of Virginia. John L. McIntosh is Associate Professor of Psychology at Indiana University and a Research Associate at the Center for Gerontological Research at the University of Notre Dame.

The Rural Elderly: An Annotated Bibliography of Social Science Research. Compiled by John A.

Krout. Greenwood Press, P.O. Box 5007, 88 Post Road West, Westport, Connecticut 06881. (203) 226-3571. $29.95. 1986. 123 pp.

In his preface to *The Rural Elderly*, John A. Krout explains that this bibliography "attempts to provide a comprehensive review of existing social science research on America's rural elderly." The term "rural" as used in the bibliography, he notes, "does not refer to a specific type of place but a wide range of places that by common understanding are seen as different from big cities and the sprawling suburban areas that spread from them."

Nearly 600 monographs, journal articles, papers, government reports, dissertations, grant reports, bibliographies, unpublished manuscripts, and research reports are listed alphabetically under 29 subject headings. Annotations provide complete information on each study, the sample size, research problems, and major findings. An author index makes it easy to locate specific works, and a geographic index arranges the entries by the location of the research work in question.

Among the many topics covered are attitudes and values, religion, death and dying, nutrition, alcohol and drug use, support networks, health, and minorities. The bibliography includes primarily recent literature—almost 90 percent of the works cited were published after 1970. Nearly 300 cross-references provide access to works which explore more than one subject.

John A. Krout is Associate Professor of Sociology and Director of Sponsored Research at the State University of New York at Fredonia.

Social Work With The Aged And Their Families. By Roberta R. Greene. Walter de Gruyter, Inc., 200 Saw Mill River Rd., Hawthorne, New York 10532. $33.95 hardback, 1986. 281 pp. $14.95 paperback.

In her preface to *Social Work With The Aged And Their Families*, Roberta R. Greene says that her book "provides a framework for implementing comprehensive psychosocial diagnosis within a family context and social work intervention based on a clinical understanding of the aged persons, the family, the community, and institutional environments."

Although Dr. Green's text utilizes existing ideas about mental health thereapy with the aged, she also presents an innovative view of treatment—the Functional-Age Model of Intergenerational Therapy. As an intergenerational treatment model, it is concerned with both the elderly person's functioning and the family system in which it takes place.

Dr. Green says that while many geriatric caseworkers have been using new methods and techniques for treatment of the elderly, "not enough has been done to conceptualize and bring together this information in a form that could be used by other professionals." The book, she says, attempts such a synthesis.

Roberta R. Greene is Senior Staff Associate for the National Association of Social Workers, Inc. in Silver Spring, Maryland. She developed materials for a national curriculum project, "Continuing Education for Gerontological Careers," sponsored by the Council on Social Work Education and funded by the Administration on Aging."

THE NUMBERS GAME

The Use of Community Services

by Donald G. Fowles*

One of every five older people in 1984 used a selected group of services provided in the community, according to a new study released by the National Center for Health Statistics (NCHS). The study, based on a nationwide survey of noninstitutionalized older people, found that the most commonly used services were those provided outside the home rather than those delivered in the home.

Data on community services are of increasing interest to program planners and policy makers because of the high costs associated with traditional health services delivered in hospitals, nursing homes, and other health care establishments. The hope is that many supportive services and some health services can be delivered outside such institutions and, consequently, that institutionalization of some of the vulnerable elderly can be averted or at least delayed.

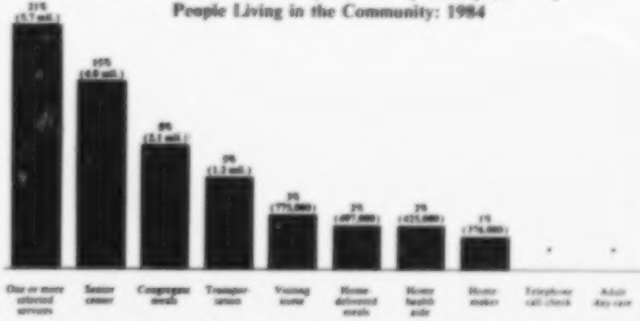
The NCHS study, conducted by Dr. Robyn Stone of the National Center for Health Services Research, found that 21 percent of the older respondents, representing 5.7 million people 65 years or older in the country, reported using one or more of a group of nine services during the 12 months prior to their interview (see figure 1). Four of the services—senior centers, congregate meals (meals at group sites such as churches and senior centers), special transportation for the elderly, and adult day care—are provided outside the home. The other five services are provided in the home and include visiting nurses, home-delivered meals, home health aides, homemakers (who provide assistance with such tasks as cooking and cleaning), and telephone call-checking.

Higher Rates for Community Services

Services provided outside the home were the only ones that were used by

Figure 1

Use of Selected Community Services by Elderly (65 +) People Living in the Community: 1984



* Number of sample cases too small to produce reliable national estimate

311

5 percent or more of the sample. By far the most popular service was senior centers. About 15 percent of the respondents, representing 4.0 million older people, reported using these centers. The next most popular service was congregate meals (9 percent, 2.1 million people), followed by special transportation for the elderly (5 percent, 1.2 million).

It should be noted that the wording of the survey questionnaire may have had the effect of double-counting respondents who used senior centers solely for congregate meals. These respondents would likely have answered "yes" to two questions: whether they used "a senior center" and whether they ate "meals in a senior center or in some place with a special meal program for the elderly." A follow-up question regarding the use of senior centers for purposes other than congregate meals would have alleviated this problem.

Four of the remaining services—visiting nurses, home-delivered meals, home health aides, and homemakers—were used by increasingly smaller numbers of respondents (from 1 to 3 percent, or one-third to three-quarters of a million people). The other services—telephone call-checking and adult day care—were used by so few respondents that reliable national estimates could not be made.

Many Services Not Counted

Although these statistics on service usage may appear low to some observers, it must be remembered that the informal support network of family members, friends, and neighbors provides most of the care for older people in the community. Some data on the assistance provided by this network were collected in this survey but were not included in this report.

The statistics in this report also do not include the experiences of people who died or were institutionalized in the year prior to the time of interview. Other research has shown that people are high users of health and supportive services in the year before their institutionalization or death. If such people could have been included in this survey, the usage rates of in-home and community services would be significantly higher.

A variety of community services were not included in this survey. Use of the omitted services by older people would be hard to measure because they are difficult to define or because they are not as widely available as many of the nine services included in the questionnaire. The missing services include information and referral, legal assistance, various types of counselling, housing and employment services, outpatient rehabilitation and physical therapy, case management, and social and recreational activities (other than those offered at senior centers).

Patterns of Usage

Over half (53 percent) of the older respondents who indicated that they used any of the specified services reported that they only used one service (mostly senior centers). Another third (34 percent) reported using two services, and only 13 percent said they used three or more services during the previous 12 months.

The data on service usage in this report are broken down by gender, age (65-74 vs. 75+), living arrangements (living alone vs. with others), and limitation of activity (moderate or severe vs. slight or none). These figures indicate service usage is more likely among women, the "old-old," live-alones, and those with moderate or severe limitations.

Many of the differences in rates of service usage (e.g., between males and females) are quite small and are probably not statistically significant. However, the results show that those older people most likely to need assistance are also those most likely to have received such help. For example, the highest rates of usage were reported by older people with moderate to severe limitations who lived alone. The usage rates for these respondents ranged from 10 to 13 percent for the in-home services providing home-delivered meals, homemakers, and home health (home health aides and visiting nurses were combined into the latter category for this analysis) and 12 to 19 percent for the services provided outside the home (senior centers, congregate meals, and transportation).

Source of Data

The data in the NCHS report came from the Supplement on Aging to the 1984 National Health Interview Survey (NHIS). The NHIS is an ongoing survey of over 40,000 households annually in the United States and is conducted by the U.S. Bureau of the Census for NCHS, a component of the Public Health Service, U.S. Department of Health and Human Services. The Supplement on Aging was administered to all household members 65 years or older and a half sample of those 55 to 64 years of age.

The data in this report are preliminary because only interviews from the first half of the year were included and because the data had not yet been edited. NCHS plans to release comparable data from the edited, full-year sample in the near future. NCHS will also release a public-use computer tape so that researchers may perform their own analyses of the full sample.

The report, *Aging in the Eighties, Age 65 and Over—Use of Community Services*, can be obtained without charge by writing to: National Center for Health Statistics, 3700 East-West Highway, Hyattsville, Md. 20782.

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* *Mr. Fowles is a statistician with the Administration on Aging.*

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REAUTHORIZATION OF THE OLDER AMERICANS ACT

Part 1

MONDAY, APRIL 6, 1987

House of Representatives,
Subcommittee on Human Resources,
Committee on Education and Labor,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 2261, Rayburn House Office Building, Hon. Dale E. Kildee (chairman of the subcommittee) presiding.

Members present: Representatives Kildee, Sawyer, Tauke and Grandy.

Staff present: Susan Wilhelm, staff director; Thomas Kelley, legislative associate; Carol Lamb, minority legislative associate; and Margaret Kajeckas, clerk.

Mr. Kildee. The hearing will come to order.

The Subcommittee on Human Resources meets this morning for its fourth hearing on reauthorization of the Older Americans Act. In previous hearings the Subcommittee has learned that the Older Americans Act and the programs that it created are an indispensable part of the lives of many of our Nation's elderly. The act enables the provision of many services, including home-delivered meals, congregate nutrition and transportation services which in turn enable many elderly to remain active and independent in their own communities.

Testimony has reinforced the fact that the Older Americans Act and the programs it authorizes are among the most successful of any Federal programs currently operating. I walk into homes and see some of these programs functioning, and you can see success and enthusiasm and dedication. It is, I think, a very good investment of our Federal dollars.

Today we will continue our discussion of general issues related to reauthorization of the act. In addition, we will direct specific attention to Title V, Community Service Employment for Older Americans.

I have stated on many platforms and in many forums that the role of the Federal Government is to promote, protect, defend and enhance human dignity. I try to examine every bill that comes before the Congress of the United States with that in mind: will this bill promote, protect, defend and enhance human dignity? Or will it tend to denigrate human dignity? That's a pretty good criterion to judge the efficacy or the value of a program. I think few programs meet this challenge as effectively as does the Older

Americans Act; I see that day in and day out. It's not theoretical with me. It's an excellent program. I've seen people actually have their dignity promoted because of the kindness they've received in the dispensing of these services. We seem to have attracted very good people in these programs, too.

One of the frustrating dilemmas that I find as chairman of this subcommittee is that on the one hand, we have expanding needs as our Nation gets older. No one could question the fact that we have expanded needs. On the other hand, we find limited resources, and that's the frustrating dilemma I find myself in. Limited resources, to a great extent, because of a tax cut in 1981, so we have fewer dollars available for these programs.

Another question in addition to this very frustrating dilemma is, where do we put these limited dollars? In the Older Americans Act, or perhaps in Medicare or in Medicaid? These are some of the questions that we are trying to get answered in the course of these hearings, and we appreciate all the witnesses who have come for previous hearings and this one today.

I'd like to welcome Mr. Fred Grandy. Do you have an opening statement, Mr. Grandy?

Mr. **Grandy**. I don't have a formal opening statement, Mr. Chairman. I would like to say that I concur with what you've said, particularly in the area of title V. It seems to me that community service employment for our elderly is a resource that's waiting to be tapped and one that I think we need some guidance on, particularly in this committee.

I would also like to personally welcome our colleague, Mr. Hammerschmidt from Arkansas, who I think has an idea that would be very helpful. It's been my concern that a lot of programs that are being administered are not coming to the attention of the people that need them the most, perhaps with the Older Americans Act and most noticeably, with some of the agricultural commodity programs that are distributed. So I hope that we could profit from his guidance today.

I would also hope, Mr. Chairman, to conduct some field hearings in my area of Algona, IA, and report back to this committee what I am sure will be favorable testimony like that we have received so far.

Mr. **Kildee**. Thank you very much, Fred.

Our first witness this morning is one of our colleagues and a good friend of mine, Congressman John Paul Hammerschmidt. We have shared ideas with one another, and he will speak on behalf of an initiative that he has introduced.

Congressman Hammerschmidt, it's good to welcome you before this committee as a colleague and as a friend.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A U.S. REPRESENTATIVE FROM ARKANSAS

Mr. **Hammerschmidt**. Thank you very much, Mr. Chairman.

First I'd like to express my deep appreciation to you, to Mr. Grandy, and to all the members of the subcommittee for this opportunity to address the subcommittee on the reauthorization of the Older Americans Act. I have an amendment that I hope you will consider as you deliberate the most effective ways to assist older persons through this legislation. I believe that my amendment is consistent with the concerns of the subcommittee.

Very simply, my amendment would add $25 million under Title III for a 1-year program that would provide direct assistance to low-income older persons so that they may attain the supplemental security income, SSI, Medicaid and food stamps to which they are entitled.

Although our Nation has been successful in its dramatic reduction of elderly poverty in the last 25 years, as of 1985 there were still 13 percent, or 3.5 million people, 65 and over who live below the poverty line, which is $5,156 for a single person and $6,503 for a couple. My own State, Arkansas, reported 30 percent of the population 65 and over with incomes below the poverty level, which is twice the national average.

According to the Social Security Administration, only 7 percent of the elderly 65 and over receive SSI. A recent national survey commissioned by the Commonwealth Fund and conducted by Lou Harris confirmed that only one-half of all persons eligible for SSI actually participate in the program. Those who appeared to be eligible were questioned about why they had not enrolled in the SSI program. Almost half said they had never heard of the program or believed that they were not eligible. My amendment was developed in response to these findings.

It is important to remember that since the minimum Social Security benefit was eliminated in 1981, SSI is the only program that guarantees a basic level of income for the elderly. The maximum Federal SSI benefit for persons with no other income is $340 for an individual and $510 for a couple. Social Security is still the major source of income for the low-income elderly. The average SSI benefit for those receiving Social Security is $115 a month. Less than 13 percent of the income for the elderly below the poverty line comes from SSI.

Only one-third of the noninstitutionalized low-income elderly receive Medicaid benefits. Medicaid is an essential program for the low-income elderly because many States pay for all or part of the deductibles and copayments that are not covered by the Medicare program. With the deductible at $520 for each hospitalization, many low-income older persons are postponing hospital care. Often they wait too long and require more extensive and costlier care when they are forced to seek hospitalization. Even if Congress were to enact a catastrophic health insurance bill, it appears that the elderly would still be responsible for one or two deductibles a year.

The food stamp program has a very low participation rate. About 50 percent of the elderly who are eligible receive them. The average elderly household could receive an additional benefit of $58 per month if they were to participate.

The entitlement programs—SSI, Medicaid and food stamps—have an enormous potential to improve the quality of life for millions of older Americans. I don't believe that anyone can claim that these benefits are too generous. According to the recent Urban Institute study on elderly poverty, in a typical situation a single older person who receives Social Security, SSI and food stamps would only be at 84 percent of the poverty line. A married couple in comparable circumstances would be at 99 percent of the poverty line.

Congress has to make a greater effort to ensure that all the people who are eligible for these benefits have an opportunity to receive them. With the national network of 673 area agencies on aging, we have a system in place that can reach a significant portion of the low-income elderly and educate them about these programs.

My amendment would work like this. The $25 million in funding would be disbursed to the State Offices on Aging under the title III formula. That would provide the smallest States with a minimum grant of about $120,000. The Administration on Aging would obtain current training and eligibility information on SSI and food stamps and forward it to the State Offices on Aging. The State offices would be responsible for obtaining information on Medicaid and any State SSI supplements. The States would also determine which area agencies would participate in the program. Any or all of the area agencies may be selected. States must ensure that they do not provide funding in amounts too small to be useful. There are three factors that the States must use in determining area agency eligibility: one, the number of older people with the greatest economic need; two, the lack of other outreach and application assistance programs, and three, special consideration must be given to rural areas.

Each State plan would describe how funds would be disbursed to the area agencies and what activities are permissible. Every funded area agency would be required to describe its outreach activities in its area plan. The area agency funds would cover staff, training, materials and transportation costs. The exact system that would be used to undertake outreach and application assistance would be determined at the area agency level since each area agency would be most knowledgeable about its community and the resources available. I would assume that the area agencies would enlist the help of their local voluntary organizations so that they would have the manpower to go into their communities and locate those people who would be eligible. It is clear that these activities are more difficult in rural areas, but that is also where we can expect to find large numbers of people who are unaware of the entitlement programs. If the area agencies are successful in registering people for these programs, the committee might wish to repeat this program every 5 years.

I hope that the subcommittee will support this amendment. I feel strongly that for a small outlay of funds we have an opportunity to improve the lives of so many older people. Thank you again for the opportunity to present my amendment to the subcommittee.

[The prepared statement of Hon. John Hammerschmidt follows:]

TESTIMONY BY THE HONORABLE JOHN PAUL HAMMERSCHMIDT
BEFORE THE HUMAN RESOURCES SUBCOMMITTEE
FOR A HEARING ON
REAUTHORIZATION ON THE OLDER AMERICANS ACT
2261 RAYBURN, 10:00 A.M.
APRIL 6, 1987

MR. CHAIRMAN, I'D LIKE TO EXPRESS MY DEEP APPRECIATION TO YOU AND THE RANKING MINORITY MEMBER, MR. TAUKE, FOR THIS OPPORTUNITY TO ADDRESS THE SUBCOMMITTEE ON THE REAUTHORIZATION OF THE OLDER AMERICANS ACT. I HAVE AN AMENDMENT THAT I HOPE YOU WILL CONSIDER AS YOU DELIBERATE THE MOST EFFECTIVE WAYS TO ASSIST OLDER PERSONS THROUGH THIS LEGISLATION. I BELIEVE THAT MY AMENDMENT IS CONSISTENT WITH THE CONCERNS OF THE SUBCOMMITTEE.

VERY SIMPLY, MY AMENDMENT WOULD ADD $25 MILLION UNDER TITLE III FOR A ONE YEAR PROGRAM THAT WOULD PROVIDE DIRECT ASSISTANCE TO LOW-INCOME OLDER PERSONS SO THAT THEY MAY OBTAIN THE SUPPLEMETAL SECURITY INCOME (SSI), MEDICAID AND FOOD STAMPS TO WHICH THEY ARE ENTITLED.

ALTHOUGH OUR NATION HAS BEEN SUCCESSFUL IN ITS DRAMATIC REDUCTION OF ELDERLY POVERTY IN THE LAST 25 YEARS, AS OF 1985 THERE WERE STILL 13 PERCENT OR 3.5 MILLION PEOPLE 65 AND OVER WHO LIVE BELOW THE POVERTY LINE ($5,156 FOR A SINGLE PERSON AND $6,503 FOR A COUPLE). MY OWN STATE, ARKANSAS, REPORTED 30 PERCENT OF THE POPULATION 65+ WITH INCOMES BELOW THE POVERTY LEVEL--TWICE THE NATIONAL AVERAGE.

ACCORDING TO THE SOCIAL SECURITY ADMINISTRATION ONLY 7

PERCENT OF THE ELDERLY 65 AND OVER RECEIVE SSI. A RECENT NATIONAL SURVEY COMMISSIONED BY THE COMMONWEALTH FUND AND CONDUCTED BY LOU HARRIS CONFIRMED THAT ONLY HALF OF ALL PERSONS ELIGIBLE FOR SSI ACTUALLY PARTICIPATE IN THE PROGRAM. THOSE WHO APPEARED TO BE ELIGIBLE WERE QUESTIONED ABOUT WHY THEY HAD NOT ENROLLED IN THE SSI PROGRAM. ALMOST HALF SAID THEY HAD NEVER HEARD OF THE PROGRAM OR BELIEVED THAT THEY WERE NOT ELIGIBLE. MY AMENDMENT WAS DEVELOPED IN RESPONSE TO THESE FINDINGS.

IT IS IMPORTANT TO REMEMBER THAT SINCE THE MINIMUM SOCIAL SECURITY BENEFIT WAS ELIMINATED IN 1981, SSI IS THE ONLY PROGRAM THAT GUARANTEES A BASIC LEVEL OF INCOME FOR THE ELDERLY. THE MAXIMUM FEDERAL SSI BENEFIT (FOR PERSONS WITH NO OTHER INCOME) IS $340 FOR AN INDIVIDUAL AND $510 FOR A COUPLE. SOCIAL SECURITY IS STILL THE MAJOR SOURCE OF INCOME FOR THE LOW-INCOME ELDERLY. THE AVERAGE SSI BENEFIT FOR THOSE RECEIVING SOCIAL SECURITY IS $115 A MONTH. LESS THAN 13 PERCENT OF THE INCOME FOR THE ELDERLY BELOW THE POVERTY LINE COMES FROM SSI.

ONLY ONE-THIRD OF THE NONINSTITUTIONALIZED LOW-INCOME ELDERLY RECEIVE MEDICAID BENEFITS. MEDICAID IS AN ESSENTIAL PROGRAM FOR THE LOW-INCOME ELDERLY BECAUSE MANY STATES PAY FOR ALL OR PART OF THE DEDUCTIBLES AND COPAYMENTS THAT ARE NOT COVERED BY MEDICARE PROGRAM. WITH THE DEDUCTIBLE AT $520 FOR EACH HOSPITALIZATION, MANY LOW-INCOME OLDER PERSONS ARE POSTPONING HOSPITAL CARE. OFTEN THEY WAIT TOO LONG AND REQUIRE MORE EXTENSIVE AND COSTLY CARE WHEN THEY ARE FORCED TO SEEK HOSPITALIZATION. EVEN IF CONGRESS WERE TO ENACT A CATASTROPHIC HEALTH INSURANCE BILL, IT APPEARS THAT THE ELDERLY WOULD STILL BE

RESPONSIBLE FOR ONE OR TWO DEDUCTIBLES A YEAR.

THE FOOD STAMP PROGRAM HAS A VERY LOW PARTICIPATION RATE. ABOUT 50 PERCENT OF THE ELDERLY WHO ARE ELIGIBLE RECEIVE THEM. THE AVERAGE ELDERLY HOUSEHOLD COULD RECEIVE AN ADDITIONAL BENEFIT OF $58 PER MONTH IF THEY WERE TO PARTICIPATE.

THE ENTITLEMENT PROGRAMS, SSI, MEDICAID AND FOOD STAMPS, HAVE AN ENORMOUS POTENTIAL TO IMPROVE THE QUALITY OF LIFE FOR MILLIONS OF OLDER AMERICANS. I DON'T BELIEVE THAT ANYONE CAN CLAIM THAT THESE BENEFITS ARE TOO GENEROUS. ACCORDING TO THE RECENT URBAN INSTITUTE STUDY ON ELDERLY POVERTY, IN A TYPICAL SITUATION A SINGLE OLDER PERSON WHO RECEIVES SOCIAL SECURITY, SSI, AND FOOD STAMPS WOULD ONLY BE AT 84 PERCENT OF THE POVERTY LINE. A MARRIED COUPLE IN COMPARABLE CIRCUMSTANCES WOULD BE AT 99 PERCENT OF THE POVERTY LINE.

CONGRESS HAS TO MAKE A GREATER EFFORT TO ENSURE THAT ALL THE PEOPLE WHO ARE ELIGIBLE FOR THESE BENEFITS HAVE AN OPPORTUNITY TO RECEIVE THEM. WITH THE NATIONAL NETWORK OF 673 AREA AGENCIES ON AGING WE HAVE A SYSTEM IN PLACE THAT CAN REACH A SIGNIFICANT PORTION OF THE LOW-INCOME ELDERLY AND EDUCATE THEM ABOUT THESE PROGRAMS.

MY AMENDMENT WOULD WORK LIKE THIS. THE $25 MILLION IN FUNDING WOULD BE DISPERSED TO THE STATE OFFICES ON AGING UNDER THE TITLE III FORMULA. THAT WOULD PROVIDE THE SMALLEST STATES WITH A MINIMUM GRANT OF ABOUT $120,000. THE ADMINISTRATION ON AGING WOULD OBTAIN CURRENT TRAINING AND ELIGIBILITY INFORMATION ON SSI AND FOOD STAMPS AND FORWARD IT TO THE STATE OFFICES ON AGING. THE STATE OFFICES WOULD BE RESPONSIBLE FOR OBTAINING

INFORMATION ON MEDICAID AND ANY STATE SSI SUPPLEMENTS. THE STATES WOULD ALSO DETERMINE WHICH AREA AGENCIES WOULD PARTICIPATE IN THE PROGRAM. ANY OR ALL THE AREA AGENCIES MAY BE SELECTED. STATES MUST ENSURE THAT THEY DO NOT PROVIDE FUNDING IN AMOUNTS TOO SMALL TO BE USEFUL. THERE ARE THREE FACTORS THAT THE STATES MUST USE IN DETERMINING AREA AGENCY ELIGIBILITY 1) THE NUMBER OF OLDER PEOPLE WITH THE GREATEST ECONOMIC NEED, 2) THE LACK OF OTHER OUTREACH AND APPLICATION ASSISTANCE PROGRAMS, AND 3) SPECIAL CONSIDERATION MUST BE GIVEN TO RURAL AREAS.

EACH STATE PLAN WOULD DESCRIBE HOW FUNDS WOULD BE DISPERSED TO THE AREA AGENCIES AND WHAT ACTIVITIES ARE PERMISSIBLE. EVERY FUNDED AREA AGENCY WOULD BE REQUIRED TO DESCRIBE ITS OUTREACH ACTIVITIES IN ITS AREA PLAN. THE AREA AGENCY FUNDS WOULD COVER STAFF, TRAINING, MATERIALS AND TRANSPORATION COSTS. THE EXACT SYSTEM THAT WOULD BE USED TO UNDERTAKE OUTREACH AND APPLICATION ASSISTANCE WOULD BE DETERMINED AT THE AREA AGENCY LEVEL SINCE EACH AREA AGENCY WOULD BE MOST KNOWLEDGEABLE ABOUT ITS COMMUNITY AND THE RESOURCES AVAILABLE. I WOULD ASSUME THAT THE AREA AGENCIES WOULD ENLIST THE HELP OF THEIR LOCAL VOLUNTARY ORGANIZATIONS SO THAT THEY WOULD HAVE THE MANPOWER TO GO INTO THEIR COMMUNITIES AND LOCATE THOSE PEOPLE WHO WOULD BE ELIGIBLE. IT IS CLEAR THAT THESE ACTIVITIES ARE MORE DIFFICULT IN RURAL AREAS BUT THAT IS ALSO WHERE WE CAN EXPECT TO FIND LARGE NUMBERS OF PEOPLE WHO ARE UNAWARE OF THE ENTITLEMENT PROGRAMS. IF THE AREA AGENCIES ARE SUCCESSFUL IN REGISTERING PEOPLE FOR THESE PROGRAMS, THE COMMITTEE MIGHT WISH TO REPEAT THIS PROGRAM EVERY FIVE YEARS.

I HOPE THAT THE SUBCOMMITTEE WILL SUPPORT THIS AMENDMENT. I FEEL STRONGLY THAT FOR A SMALL OUTLAY OF FUNDS WE HAVE AN OPPORTUNITY TO IMPROVE THE LIVES OF SO MANY OLDER PEOPLE. THANK YOU AGAIN FOR THE OPPORTUNITY TO PRESENT MY AMENDMENT TO THE SUBCOMMITTEE.

Mr. KILDEE. Thank you very much, Congressman Hammerschmidt. You are a perfect example of the fact that there are people who are really meaningfully concerned with human dignity on both sides of the aisle here in Congress. I have always enjoyed working with you.

You mentioned in your testimony, Congressman, that in many States Medicaid pays for all or part of the deductible costs associated with a hospital stay. Do you have any knowledge of how many States actually have Medicaid programs that pay for the deductibles?

Mr. HAMMERSCHMIDT. Well, the Health Care Financing Administration doesn't keep that data, but they estimate that about half the States cover all the deductibles. The other States do a variety of things, such as paying for a portion of the deductibles, and that's the best information that we have at the moment on that.

Mr. KILDEE. OK. About half, then, would pay for the——

Mr. HAMMERSCHMIDT. About half is the data that we have.

Mr. KILDEE. OK.

Your proposal also calls for funds to be distributed under the current title III formula. Have you received any direction or feedback from State units or area agencies as to whether they could actually and effectively perform the duties outlined in your proposal?

Mr. HAMMERSCHMIDT. Well, Mr. Chairman, I don't think that the amendment has to be funded under title III. But after contacting many of the aging organizations, it was clear to me that there was a variety of other formulas that could be devised. I selected the title III formula because it was an accepted system for distribution of funds to the States. Another suggestion was to give money to the States based only on the number of older persons. I believe that you and the other members of the subcommittee are in the best position to determine the funding formula; after all, the bill is nothing but an idea put into legislative form, so I would certainly defer to the expertise on this committee.

Mr. KILDEE. Thank you very much.

Mr. Grandy?

Mr. GRANDY. Thank you, Mr. Chairman.

Congressman, I want to delve a little more deeply into the special consideration given to rural areas. I represent a rural area; our area aging associations are in need of a greater kind of outreach program. I think this is an idea whose time has come, and quite honestly, if I have any criticism with it, it may not go far enough; because I know, for example, in a lot of my areas the commodity surplus programs, food stamps, and so forth are distributed without any knowledge of how they might be best used. For example, if somebody applies for food stamps, they don't necessarily have the background in nutrition or making a food dollar travel farther to really provide nutrition for themselves. And I'm not talking only about elderly people; I'm talking about young people with families.

Have you found this to be the case in your area, that perhaps there is a proliferation of programs but not a networking to make the maximum use of your services?

Mr. HAMMERSCHMIDT. Yes, I think that's true. And I think that given the enactment of this amendment, that we would go a long way toward forming a network and performing the proper distribution and the proper judgment in decisions to be made toward the most efficient use of the entitlements that are available.

Mr. **Grandy**. Do you see this $25 million in addition to reaching out, to coordinating an information network for these programs, Department of Agriculture, Health and Human Services, so that people perhaps have a kind of "one stop shop"?

Mr. **Hammerschmidt**. I do, and I think that when you give this your consideration in this committee, you can weave that into the legislation or put it in the report language or make sure that that is accomplished.

Mr. **Grandy**. In terms of reaching out in elderly communities, and I'm sure you find this in your district, as well, clearly the hub of activity is the Community Service Center, and that's where most folks congregate for meals and social events and so forth. Would there be a possibility of perhaps deputizing or putting together a kind of elderly volunteer task force to reach out to some of these people that are not aware of these programs? In other words, educating a few and training them to train the others under your amendment; do you see that as a possible way to give consideration to rural areas?

Mr. **Hammerschmidt**. I do. I think that the area agencies on aging can only give the leadership. It's very, very dependent on volunteer service, and I think it's a major part of the idea. You have a lot of people out there that want to volunteer; you know, we have this RSVP and other programs that do a great job in this.

Mr. **Grandy**. I was going to say RSVP. It seems to me that we have an opportunity to address the community service needs as well as what you're talking about, the nutritional and health needs.

So I am very supportive of your amendment and will do everything I can to push this idea in my area, as well.

Mr. Chairman, I yield back the balance of my time.

Mr. **Kildee**. Thank you.

Mr. Sawyer?

Mr. **Sawyer**. Thank you, Mr. Chairman. I don't have any questions for the Congressman either, except to echo the commendations that he's received from others in terms of the direction that he seeks to go, the kind of effort that I had to make as a mayor, Mr. Chairman, in trying to pull together the wide range of community activists, particularly in service to older persons in our community. In an attempt to make up with volunteerism what we had lost and could anticipate losing in terms of dollars, that was an important undertaking. The ability to expend those dollars that are available in the most efficient way, and in an effort to reach those who most need that help, is certainly a worthwhile goal.

Thank you.

Mr. **Kildee**. Thank you, Mr. Sawyer.

Mr. Hammerschmidt, we appreciate very much your testimony this morning and look forward to working with you to try to resolve this and various other problems that our older Americans have.

Mr. **Hammerschmidt**. Thank you, Mr. Chairman. I want to express my appreciation not only for your leadership on this committee, but for your leadership in the House. You know, the Speaker picks you a lot to preside up there, and you do a great job, and I appreciate that. Whether you're presiding over the whole House or this committee you always have the leadership qualities and the unfailing courtesy that you bring to our body, and I appreciate it. And I appreciate your friendship.

Mr. KILDEE. Thank you very much.

Mr. HAMMERSCHMIDT. Thank you, sir.

Mr. KILDEE. Our next witness will be Ms. Dolores Battle, Administrator, Office of Job Training Programs, Department of Labor, Washington, DC.

We welcome you before this subcommittee.

STATEMENT OF DOLORES BATTLE, ADMINISTRATOR, OFFICE OF JOB TRAINING PROGRAMS, U.S. DEPARTMENT OF LABOR, ACCOMPANIED BY PAUL A. MAYRAND, OFFICE OF SPECIAL TARGETED PROGRAMS

Ms. BATTLE. Thank you, Mr. Chairman. I have a statement to be submitted for the record.

Mr. KILDEE. We will include it in the record in its entirety immediately following your oral presentation, and you may summarize in any fashion you wish.

Ms. BATTLE. Mr. Chairman and members of the committee, thank you for this opportunity to appear before you today to discuss the Department of Labor's activities under title V of the Older Americans Act. Accompanying me today is Paul Mayrand of our Office of Special Targeted Programs, which administers the title V program.

Mr. KILDEE. We particularly welcome Mr. Mayrand. We discovered we went to a very small college in Detroit together a few years ago.

Ms. BATTLE. As you know, the authorization for appropriations for this program expires at the end of this fiscal year. The administration is proposing a 3-year extension of the authorization through fiscal year 1990. I would like first to outline the current scope of the title V program, also known as the Senior Community Services Employment Program, and then discuss other older worker activities.

The title V program employs elderly low-income persons in part-time community service jobs. All program participants are age 55 or older. Participants work an average of 20 hours a week and are employed in a variety of community service activities, such as health care, home repair and day care, beautification, conservation and restoration efforts. They work in schools, hospitals, parks, community centers, and other Government and private nonprofit facilities. The participants are paid an average hourly wage of $3.45 in these community service jobs.

Over three-fourths of title V participants are age 60 or older, and nearly half are 65 or older.

At the present time, the title V program supports 61,000 job opportunities and is funded at the level of $312 million for the 12-month period that ends on June 30, 1987. The fiscal year 1987 appropriation of $326 million will fund approximately 63,800 job opportunities. We propose to continue this level in fiscal year 1988.

In the past few years, efforts have been made to move program participants into unsubsidized jobs, primarily jobs in the private sector. As a result, more workers are being placed into regular jobs, with the rate increasing from 11 percent in 1981 to over 20 percent in 1986.

The title V program is administered in part by national organizations and in part through State grants. About 78 percent of the amount appropriated for title V is reserved for eight national organizations. Three of these operate primarily in rural areas: Green Thumb, the Forest Service, and the National Center on Black Aged. The National Urban League operates primarily in cities; the National Council of Senior Citizens, the American Association of Retired Persons, the National Council on Aging, and the National Association for Hispanic Elderly operate mainly in urban and suburban areas, and in a few rural areas.

The remaining 22 percent of the funds is provided to States. These State grant funds are generally administered by the various State agencies on aging.

A recent evaluation of this program by a private research firm identified a very high degree of program satisfaction among enrollees and the agencies where they work, a finding which is consistent with previous evaluations which have been done.

The Department also has just completed a study of the unit cost used in budgeting for the title V program, a copy of which I have with me today in case it hasn't reached you. This study was undertaken at the request of Congress to determine whether adjustments should be made in that unit cost. Let me summarize briefly the results of that study.

We reviewed detailed information provided by our national sponsors and compared data from 1981 to 1986. While the data showed sponsors made adjustments in some spending areas for inflation and programmatic purposes, the actual service year cost for the program year ending June 30, 1986, was approximately $4,800, or some $311 per service year below the current unit cost of $5,111 used for planning and budgetary purposes.

As a result of this study, the Department feels that the unit cost is adequate for the foreseeable future.

Mr. Chairman, as you know, title V is not the only DOL-funded employment and training program that serves older Americans. They are eligible for and receive training and employment services under the JTPA, Job Training Partnership Act, title II-A, General Grant to the States, and the title III program for dislocated workers. Moreover, 3 percent of each State's training grant allotment under II–A of JTPA is reserved for older workers.

We are requiring the title V sponsors to coordinate their programs more closely with other employment programs, particularly the JTPA. This makes the title V program available to more people through movement of title V enrollees into JTPA training positions.

In summary, title V is an effective program, simple in design and execution, but flexible enough to meet the needs of enrollees and their communities.

Thank you, Mr. Chairman. This concludes my prepared remarks. We will be pleased to answer any questions that you or the committee members may have.

[The prepared statement of Dolores Battle follows:]

STATEMENT OF
DOLORES BATTLE
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

April 6, 1987

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to appear before you today to discuss the Department of Labor's (DOL) activities under Title V of the Older Americans Act and our future plans for this program. Accompanying me today is Paul A. Mayrand of our Office of Special Targeted Programs, which administers the Title V program.

As you know, the authorization for appropriations for this program expires at the end of this fiscal year. The Administration is proposing a 3-year extension of the authorization, through Fiscal Year (FY) 1990.

I would like, first, to outline the current scope of the Title V program, also known as the Senior Community Service Employment Program (SCSEP), and then discuss other older worker activities.

The SCSEP employs elderly, low-income persons in part-time community service jobs. All program participants are age 55 or older. Participants work an average of 20 hours a week and are employed in a variety of community service activities such as health care, home repair and day care, and in beautification, conservation and restoration efforts. They work in schools, hospitals, parks, community centers, and other government and private nonprofit facilities. The participants are paid an average hourly wage of $3.45 in these community service jobs.

The SCSEP also provides participants with personal and job-related counseling, annual physical examinations, job training, and, in many cases, referral to regular jobs in the competitive labor market.

Over three-fourth of SCSEP participants are age 60 or older, and nearly half are 65 or older. Over 67 percent are female, over half have not completed high school, and about 85 percent have a family income below the poverty level.

At the present time, the SCSEP program supports 61,000 job opportunities and is funded at the level of $312 million for the 12-month period that ends on June 30, 1987. We will begin spending the currently-appropriated FY 1987 appropriation of $326 million on July 1, 1987, which will fund approximately 63,800 job opportunities. We have proposed to continue this level in FY 1988.

In the past few years, efforts have been made to move program participants into unsubsidized jobs, primarily jobs in the private sector. As a result of this effort, progressively more workers are being placed into regular jobs, with the rate increasing from 11 percent placed in 1981 to over 20 percent in 1986. As a part of our effort to move participants into private sector jobs, the Department of Labor and the Department of Health and Human Services jointly funded the National Center on Black Aged to test new approaches to preparing older workers for placement into private sector jobs. The experience and knowledge gained from these projects will lead to improvement in the transition of participants into private sector jobs.

The Title V program is administered in part by national organizations, and in part through State grants. Appropriations language for Program Year 1987 has reserved 78 percent of the amount appropriated for Title V for eight national organizations. Three of these operate primarily in rural areas--Green Thumb, Inc., the U.S. Forest Service, and the National Center on Black Aged. The National Urban league operates primarily in cities, while the National Council of Senior Citizens, the American Association of Retired Persons, the National Council on Aging, and the National Association for Hispanic Elderly operate mainly in urban and suburban areas, and in a few rural areas. Local projects are operated through contracts with State or local nonprofit organizations such as agencies on aging or community groups, and through local affiliates of the national organizations. The remaining 22 percent of the funds is provided to States. These State grant funds are generally administered by the various State agencies on aging.

A recent evaluation of this program by a private research firm identified a very high degree of program satisfaction among enrollees and the agencies where they work. This finding is consistent with previous evaluations which found the SCSEP meeting its legislative objectives.

The Department also has just completed a study of the unit cost used in budgeting for the Title V program. This study was undertaken at the request of Congress to determine whether adjustments should be made in that unit cost which has not been changed since 1981. Let me summarize briefly the results of our study. To assess changes in program expenditures over the past five years we reviewed detailed information provided by our national sponsors and compared the data for 1981 and 1986. While the data showed sponsors made adjustments in some spending areas for inflation and programmatic purposes, the actual service year cost for the program year ending June 30, 1986, was approximately $4,800, or some $311 per service year below the current unit cost of $5,111 used for planning and budgetary purposes. As a result of this study, the Department has determined that the unit cost is adequate for the foreseeable future. Because of the gap between the actual and budgeted cost of positions, we may be able to totally or partially offset cost increases without compensatory increases in the appropriation.

Mr. Chairman, as you know, SCSEP is not the only DOL funded employment and training program that serves older Americans. The Job Training Partnership Act (JTPA) authorizes training and placement of economically disadvantaged older individuals in employment opportunities with private business concerns. They are eligible for and receive training and employment services under the Title II-A general grant to the States and the Title III program for dislocated workers. Moreover, three percent of each State's training grant allotment under Title II-A of JTPA is reserved for this purpose. This amounts to approximately $55 million for the program year beginning July 1, 1987. The Administration's proposed $980 million workers readjustment assistance program (WRAP) will also service older workers.

We are requiring the SCSEP sponsors to coordinate their programs more closely with other employment programs, particularly the JTPA. This makes the SCSEP program available to more people through movement of SCSEP enrollees into JTPA training positions which also permits the development of new skills through classroom instruction and other formal learning situations. Over 1,600 SCSEP enrollees have participated in JTPA and many have been placed into full-time jobs. At the present time there are over 240 JTPA-SCSEP related agreements. We believe it is important to effectively utilize all the available resources of the Department on behalf of older workers, and we will continue to strongly encourage this type of close program coordination. We will work closely with SCSEP sponsors to ensure progress in their coordination efforts.

Identifying the needs of the workforce and developing appropriate solutions will become increasingly important if this Nation is to compete successfully in international commerce. Bureau of Labor Statistics projections indicate that prime age workers will constitute a larger share of the labor force in the years ahead, and the average age of the workforce will rise. With fewer young workers entering the labor force between now and the turn of the century, older workers will become a particularly valuable resource. To take advantage of this resource, retraining of the older worker will become more important. This retraining will impact on the older worker as well as other workers. Consequently, the practical experience that we have gained with older workers under the SCSEP and JTPA will form the foundation upon which future training and employment policies will be based.

In summary, the SCSEP is an effective program, simple in design and execution, but flexible enough to meet the needs of enrollees and their communities. We hope to continue through emphasis on coordination and unsubsidized placement, as well as effective management, to make the program more effective in serving eligible persons.

Thank you, Mr. Chairman. This concludes my prepared statement. We will be pleased to answer any questions that you or other members of the Subcommittee may have.

Mr. **Kildee**. Thank you, Ms. Battle. We appreciate your testimony.

In my own Congressional district, the National Council of Senior Citizens has the title V program, working with the Flint Board of Education. They train and provide employment for in-home health care workers. It's older people helping older people, and it's a very successful program there. So we appreciate the great administration you're giving to programs like this.

The act now allows the Department to provide a waiver of the administrative cost cap in cases where the title V sponsor can demonstrate that it cannot meet the cap requirement. How many waivers were requested and approved or denied for the current program year?

Ms. **Battle**. Four waivers were requested this year, and we approved one.

Mr. **Kildee**. Only four, and you approved one?

Ms. **Battle**. Yes.

Mr. **Kildee**. All right.

The committee has been asked by various people and groups to consider an amendment to return the administrative cap back to the 15 percent originally provided in the regulations. Does the administration have a position on this?

Ms. **Battle**. Yes. We feel that the current waiver permission, the system of reviewing and granting individual waivers is adequate for our purposes. As you can see, we haven't had a great many requests. We probably will have a few more this year since the cap is going down to 12 percent. But in our unit cost study we found that the administrative costs are running about 10.5 percent, a little bit under 11 percent, so we think there's enough room in there for us to handle this through the existing mechanisms.

Mr. **Kildee**. So four were requested and one was granted?

Ms. **Battle**. That's right.

Mr. **Kildee**. The other three were considered to have insufficient evidence that they should be granted, or did not present enough of a case that the waiver should be granted?

Ms. **Battle**. Insufficient evidence.

Mr. **Kildee**. All right.

Mr. Grandy?

Mr. **Grandy**. I have no questions at this time, Mr. Chairman.

Mr. **Kildee**. Mr. Sawyer?

Mr. **Sawyer**. Thank you, Mr. Chairman.

Just to follow up on that last question, what standards of judgment were used to determine whether a waiver ought to be granted?

Ms. **Battle**. I'm going to ask Mr. Mayrand to respond.

Mr. **Sawyer**. All right.

Mr. **Mayrand**. In the case of the four requests, the one that was granted was for the State of Alaska based, in part, because of the obvious cost difference between Alaska and the lower States. The other was the additional information provided by the State, increases in certain costs that we felt justified in.

The other three, I believe, had little or no information to justify or document why there should be an increase.

Mr. SAWYER. I can understand why a dollar amount might be affected by Alaska. I'm not sure I follow why a percentage would be affected.

Mr. MAYRAND. Well, it would cost slightly more to operate a program where you have a much larger territory to consider. Transportation costs will be greater, et cetera.

Mr. SAWYER. OK.

Let me ask another question, then, regarding the pursuit of 20-percent transfer into unsubsidized jobs. My district is not as affected as some might be, but the concern about the ability to meet that requirement in areas that have substantially higher unemployment than the rest of the Nation causes me some concern. Could you comment on that, please?

Ms. BATTLE. The 20 percent requirement is, in part, a reflection of the overall percent that has been transitioning into private employment. It's actually about 21 percent overall; but it is a goal, not a requirement, and we do stress that nobody has ever been sanctioned, no individual grantee, for not meeting that goal, or defunded. So we recognize that there are some areas, particularly rural areas, where it is very difficult to do that. But we try to set that goal for national purposes.

Mr. SAWYER. I think it must be an appropriate goal because there are a number of programs that are currently meeting that, and I guess that's where it was derived from.

Do you have any difficulty in setting that kind of goal with the potential consequence of weighing judgments in favor of younger senior workers?

Ms. BATTLE. I suppose that's conceivable. We haven't noticed any trend in that direction over the four or five years that we've been making that effort. It is conceivable that those people who are younger might be more likely to move into jobs in the private sector, but that will open slots for more people coming into the program.

Mr. SAWYER. Subsidized slots?

Ms. BATTLE. That's right, subsidized slots.

Mr. SAWYER. Thank you very much, Mr. Chairman.

Mr. KILDEE. Right now the cap is 13.5, and it's going to drop to 12 percent July 1. Could we reasonably expect, then, more requests for waivers when that does drop to 12 percent?

Ms. BATTLE. Oh, I think that's likely.

Mr. KILDEE. Now, within your agency have you developed objective criteria to decide which waivers will be approved. You mentioned one, transportation costs in Alaska. Do you have some objective criteria you look at to see why that waiver might be granted?

Ms. BATTLE. I'm going to refer that to Mr. Mayrand.

Mr. MAYRAND. We have received most all of the proposals from all of the sponsors for the program year 1987, which will commence on July 1 of this year. We have made a quick review of the administrative requests, and I believe that about six or so will be requesting a waiver. The vast numbers in, so far, have indicated they can live at the 12-percent cap, which is what the act requires effective July 1.

We will be looking at the six requests, again, in relation to documentation provided. If they can indicate that certain costs have increased and show us where the costs are, specifically by line items, liability insurance, salaries, transportation, et cetera—based upon a review of that and any of the other considerations; they may indicate that it may cause them to reduce further, perhaps, the size of the staff, or perhaps impact adversely the unsubsidized placement efforts. We look at all of that and then make a decision to grant the waiver, or indicate, perhaps, that the waiver requested, whatever the amount, perhaps should be reduced slightly to make it closer to the 12 percent required on July 1.

Mr. **Kildee**. Does the cap have the effect of forcing agencies to keep their administrative costs down? I guess the answer would be yes. Is that a reasonable incentive or an unreasonable incentive? Perhaps you could give some examples.

What I worry about is that perhaps there may be some cuts that might be OK in the short term, and in the long term might be ineffective in keeping their administrative costs down. Pressure would exist, wouldn't it, to keep this cost down? Do you think the pressure is within the range of reason? It will go down to 12 percent next year; is that within the range of reason?

Mr. **Mayrand**. Well, it's a hard one to predict, at what point the 12-percent cap, as an example, may become unreasonable. We do understand that, based upon the review we made of the expenditures, that in a good number of cases the sponsors had reduced the size of their staffs. Other administrative costs have gone up; the fringe benefits, health, et cetera. There has been some consolidation of the projects. The study itself also indicated that although the unit cost is $5,111, based on actual expenditures, it is closer to $4,810, as Ms. Battle indicated, which would indicate that perhaps there is a $300 or 6-percent cushion between what we are now offering and what the unit cost may be.

The concern is a very real one. We are also concerned about that.

Mr. **Kildee**. Mr. Grandy?

Mr. **Grandy**. Yes, Mr. Chairman.

I'd like to ask if you have any information on how participants in title V that have moved into unsubsidized employment are faring? There was a study that was going to come out on this, wasn't there? Do you have any kind of data at all of the movement and progress of moving to unsubsidized employment yet?

Mr. **Mayrand**. There was a study done. I think the bottom line was that those that were moved into unsubsidized placement earned more than they would under the program; but in fairness, that is because in some cases they are now working full-time versus part time before, so you are given higher wage earnings.

We have also found that those that tend to be transitioned tend to be, in part, those between 55 and 59; not totally, but perhaps a larger number. The reason being, again, because people at that age cohort tend to have less support from other Federal assistance. They're not on Social Security; they may not be getting anything else. Economically, therefore, they tend to most in need; therefore they may have a stronger motivation to seek full-time work. In many cases they are women, recently divorced or widowed, who need full time employment.

So we believe that the transition has resulted in enrollees obtaining jobs that do give them greater earnings.

Mr. **Grandy**. I wanted to ask this, too. Appropriations language in recent years has preempted the formula in title V. If the formula was used, what would be the effect in allotting funds between national contractors and the State agencies?

Mr. **Mayrand**. That would be a very hard one to answer because we have been using, as you probably know, the appropriation act requirement of 78/22 for the last 3 years. So we would have to have a computer run to give us a sense.

My gut feeling, and I wouldn't use it for anything, is that it probably would not make that substantial a difference. Rather than 78/22, maybe 77/23 or something. I don't think it would be that radical a difference.

Mr. **Grandy**. In other words, you wouldn't see a larger proportion of the funds going to the State agencies?

Mr. **Mayrand**. Again, I am only guessing. We would have to have a study done.

Mr. **Grandy**. Thank you.

Thank you, Mr. Chairman.

Mr. **Kildee**. Mr. Sawyer? Any questions?

Mr. **Sawyer**. No more questions, Mr. Chairman, just a comment that I think it might be useful at some point to begin to make more specific the kinds of standards that agencies would seek to work toward in seeking waivers. The specific standards, I think—I know that in dealing with other agencies it was difficult when we didn't know what the standards were, and we would have some sense of what is appropriate if we had those written down. I would appreciate that if we could do that.

Mr. **Kildee**. I think that's an excellent point. I think as much as possible, some objective standards for waivers would be useful, because we're all subjective people, too; we can't separate that. But as much as possible, some objective standards, and I'm sure that's something you're constantly working on. But if you could get that in some type of form, recognizing at the same time that we don't want to be so cold and harsh that we won't allow some flexibility, too. So it's a happy medium that we're asking you to achieve. That's why when we do legislate, we leave some room for the agencies to use some discretion, but the discretion should be carefully used. I appreciate the fact that you're working on that to make sure there is some objective criteria to determine those waivers.

We really appreciated your testimony this morning. We're not going to keep you long. You've been working very closely with us, and we will continue to work closely with you as we write this reauthorization. We'll probably be contacting you for some more specific information as we go along.

Thank you very much.

Ms. **Battle**. Thank you, Mr. Chairman.

Mr. **Kildee**. Our next witness is Ms. Sonia Crow, Associate Administrator, Food and Nutrition Service, U.S. Department of Agriculture.

I have been in many places where I have seen some of your products being well utilized.

STATEMENT OF SONIA F. CROW, ASSOCIATE ADMINISTRATOR, FOOD AND NUTRITION SERVICE, U.S. DEPARTMENT OF AGRICULTURE, ACCOMPANIED BY STANLEY C. GARNETT, ASSISTANT DEPUTY ADMINISTRATOR FOR SPECIAL NUTRITION PROGRAMS, FOOD AND NUTRITION SERVICE

Ms. Crow. We appreciate that kind comment, Mr. Chairman. We think that the commodity distribution system that we have right now is a very valuable one for promoting nutritional well-being for a wide variety of people in need, including people within the elderly category as well. Thank you for your kind comments.

We also thank you and members of the committee for providing us with an opportunity to appear before you today to discuss the contribution that USDA plays in the nutritional well-being of older Americans under the Older Americans Act.

Appearing with me today is Mr. Stan Garnett, who is the Assistant Deputy Administrator for Special Nutrition Programs at the Food and Nutrition Service, and under his jurisdiction specifically is the nutrition program for the elderly.

Mr. Chairman, with your permission I would like to submit formal comments for the record but spend the time that we have today with members of the committee to focus all of my comments on a proposed bill to amend the Older Americans Act that the Department has recently delivered to the Congress.

Mr. Kildee. Your entire statement will be included in the record immediately following your oral presentation.

Ms. Crow. I appreciate that very much, Mr. Chairman.

The specific purpose of the bill that we have delivered to Congress is to simplify program funding in the nutrition program for the elderly by giving to States a fixed yearly grant in place of the per meal reimbursement rate mechanism that we use currently.

As this subcommittee knows, USDA's role in the NPE is limited solely to providing commodities or cash in lieu of commodities for meals served in accordance with a set rate of reimbursement per meal that is specified in the Older Americans Act. Although funding is made available under the act on a formula basis, the Secretary of Agriculture by law cannot provide States with more funds than are appropriated. And since the final reimbursement rate per meal, up to the rate specified in the act, cannot be calculated until the total number of meals served during the year throughout the United States is reported by the States, the Department cannot announce—and the State and local providers, in turn, cannot know with any certainty—the final per meal rate that they will receive until months after the end of each fiscal year.

Obviously, we believe this funding process promotes uncertainty at all levels. The best example of this uncertainty occurred in 1985. I don't think I should use the words "best example;" I think the worst example occurred in 1985, for those of you who are familiar with the machinations that we went through in that year, to try to bring some certainty into what was, indeed, an uncertain world. In that year the Department had to announce officially four different rates for per meal reimbursement; and the local providers did not know, and we had no way of telling them with any certainty until February of 1987, what their per meal reimbursement rate was actually going to be. We think that this level of uncertainty, while it occurred with particular ferocity in 1985, theoretically could occur again in any given year under the current mechanism that is in place, and that is the real reason that we have proposed this bill for submission and for your consideration.

Specifically what would occur if this bill were passed would be that there would be a fixed yearly grant which each State would receive, and this would be based upon its proportional share of the amount of funds appropriated and the number of meals served during the preceding fiscal year within the State. It is certainly the Department's intent that once the States receive this money, that they in turn will pass along all of the funding on the same proportional basis to the local providers that are actually serving the meals.

Under a grant system, as opposed to a per meal reimbursement rate system, program operators would know in advance—and we think this is the important point—they would know in advance, at the beginning of each year, how much funding they would receive for that year, and then they could plan accordingly and make their arrangements and have some sense of where they would be going for that year.

We feel that a grant proposal is certainly one that should be acceptable to States, since States are used to dealing with grants under the other AOA programs. Also, under this proposal there would be no change in the way that food would be distributed at the local level or in the way that the meals would be provided by the locals. The only change would be that the local people and the States would know up front, in advance, how much money they were going to have to run and manage their programs for the coming fiscal year, and we think that level of certainty is one that would be certainly welcomed by the local providers, by the States, and which the Department feels would be an important improvement and advancement in this program.

Mr. Chairman, that concludes my remarks. We would be pleased to answer any questions that you or members of the committee might have on this grant proposal.

[The prepared statement of Sonia Crow follows:]

TESTIMONY OF SONIA F. CROW

ASSOCIATE ADMINISTRATOR
FOOD AND NUTRITION SERVICE
U.S. DEPARTMENT OF AGRICULTURE
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
APRIL 6, 1987

Thank you for your invitation to appear today to discuss the role played by USDA in contributing to the nutritional well - being of older Americans pursuant to the provisions of the Older Americans Act. I am pleased to be a part of this hearing and will attempt to describe our efforts in this important area of program activity.

At the outset, I need to emphasize that the role USDA presently plays in the Nutrition Program for the Elderly (NPE) is limited solely to providing commodities or cash in lieu of commodities for meals served according to a set rate of reimbursement specified in the Older Americans Act.

The amount of food or cash that USDA gives each State is based on the number of meals served in the program and the level of assistance per meal authorized by legislation. USDA will be able to subsidize 241 million meals this year.

USDA has no involvement in operating or managing the Nutrition Program for the Elderly. It makes policy decisions only related to meal reimbursement. The Administration on Aging (AOA) of the Department of Health and Human Services (DHHS) holds the primary responsibility for this program and is in a more authoritative position to gauge results and successes. However, as funding is an important component of any program, I would like to turn now to USDA's role in the NPE.

When USDA first became involved with the Nutrition Program for the Elderly, the program was an outlet for surplus foods and price-support commodities, much like the school lunch progam. As the years passed, however, legislation was modified to allow cash in lieu of commodities and gradually most States have chosen to receive subsidies in cash rather than in commodities. Today about 95 percent of our contribution is in the form of cash.

Grant Proposal

On March 24, 1987, the Department delivered to the Congress a draft bill to simplify program funding through the use of a fixed yearly grant. The bill would establish a procedure whereby each State would receive annually a proportionate share of funds appropriated for the NPE. Each State's share would be based on the number of meals served within the State under Titles III and VI of the Older Americans Act during the preceding fiscal year.

We believe that the proposed bill would result in major improvements in the program. State and local agencies would know at the beginning of the year how much funding they would receive for the year. The authorized funding levels in the proposed legislation reflect projected food cost inflation. These changes would assure a more efficiently run program, since program operators would be able to plan in advance based on a stable funding level. The bill also would eliminate the confusion which has resulted in the past when it has been necessary to adjust the per meal rate during and after the end of the fiscal year. This situation occurs because although the NPE is an annually appropriated program, each meal providers' total program share can be severly affected by the funding distribution mechanism required under current NPE law. Within the States, there is a reimbursement rate set for meals that is increased each year to account for inflation, and every meal served receives the per meal subsidy. However, if the number of meals served times the reimbursement rate exceeds the funds available, then the Department must reduce the per meal subsidy so that all meals served are reimbursed at the same level. An example of the funding problems created is best illustrated by our Fiscal Year 1985 experience. In that year, the Department, in accordance with law, had to announce four different reimbursement rates.

The original "authorized" per meal rate was 58.75 cents based on inflating the previous year's rate for the CPI for food away from home. In February of 1985, FNS announced a per meal rate reduction to 56.76 cents. This was due to an estimate of 212.8 million meals and an appropriation of $120.8 million. Later that year, a revised estimate of 225 million meals, about a 12 million increase, caused the per meal rate to be adjusted again. It was reduced to 53.61 cents. Finally, in early 1986, the Older Americans Act Amendments were passed setting the Fiscal Year 1985, 1986, and 1987 per meal reimbursement rates at 56.76 cents. This example shows clearly how a yearly fixed grant would help to alleviate this kind of confusion.

The concept of a grant is nothing new to the States since other AOA programs are funded in this manner. In response to local agencies' concerns our proposal clarifies that the entire grant must be passed through to local agencies as meal support to ensure that the funds are not used for other Title III or VI programs. A grant will not change the way that food is distributed at the local level, and providers will not need to change the way that they provide meals. Only the method of distributing appropriated funds will be different. Commodity usage flexibility will be maintained because States will still be able to obtain all or part of their grant in the form of commodities.

Increased Use of Commodities

While advocating the need for a yearly fixed grant, we have also initiated efforts to increase the use of commodities in NPE. The Department's rules with respect to commodity usage is more liberal than at any other time.

Last year, the Department announced a change in policy with respect to the availability of bonus commodities to the NPE.

Bonus commodities are those surplus commodities which the Department offers to a State at no cost for use in feeding programs. Previously, only States electing to receive 50 percent of their NPE support in the form of commodities were eligible to receive bonus commodities other than dairy products which are available to all States. Under the Department's new policy, if a State agrees to take just 20 percent of its NPE support in the form of commodities, it may order the full range of bonus commodities, which currently includes ground and canned beef as well as flour and various fruit, vegetable and poultry items as they are available.

In addition to this policy change, USDA recently entered into a cooperative agreement with the National Association of Nutrition and Aging Services Programs (NANASP) to encourage elderly congregate feeding sites to use commodities. NANASP will soon hold seven conferences across the country to demonstrate the quality and benefits of USDA commodities. We believe this effort will encourage providers to seek more commodities as they learn more about the benefits they get from using commodities.

Conclusion

In conclusion, USDA is proud of its role in helping to meet the nutritional needs of older Americans under the Older Americans act. We believe it is imperative that more commodities be utilized to merge the vital objectives of helping farmers and providing nutritious meals for the elderly, that a grant be instituted to simplify the program, and that we continue to strive to give the States the flexibility they need in obtaining commodities.

That concludes my remarks, Mr. Chairman. I shall be pleased to respond to any questions.

Mr. **Kildee**. Thank you very much. I think we've structured the debate quite well right now.

I have this question. We have received testimony in our hearings at various places that the commodity reimbursement program as currently structured is a major incentive for encouraging the establishment of new nutrition sites. Based solely on the availability of the commodity reimbursements, for example, States have been able to generate some non-Federal funds to establish new meal sites in areas where programs have not previously operated.

Is there any provision in your new proposal that would enable this practice to continue?

Ms. **Crow**. Mr. Chairman, I'm not sure I completely understand the full import of what you're saying. Certainly, under this proposal there should be no change in the way the programs are operated other than when people would know, either at the beginning of the fiscal year or having to wait until months after the fiscal year about the specific amount of money. With a per meal reimbursement rate, the providers really have no way of knowing; in fact, there is more uncertainty in the program under the current system than there would be with a fixed grant. All other mechanisms would stay in place.

So with that general statement, I don't know if that really responds to your question.

Mr. **Kildee**. Well, right now we reimburse on a basis of current year, and that might create some problems; but we generally have addressed that with supplementals before. I think I was the chief sponsor of one supplemental because, near the end of the fiscal year, there was a need for additional dollars for that.

Your proposal would go back to the previous year, which would tend to lock in the size of that program and make it, I think, more difficult for the establishment of new sites.

Ms. **Crow**. Let me see if I can address that question. Certainly, by definition, we have to use the preceding year because that's the only data that we have available to determine each State's appropriate proportional share of the amount of funds appropriated. But the changes from year to year ought to be relatively modest; and of course, a State would make it up in the next year depending on the number of meals that they served in a given year. It would then be their proportionate share of that year's amount; so there would be, in fact, some time lag involved. But we think that the shifts between the preceding year and the current year in terms of winners or losers would be a very modest shift, number one. Number two, we think the advantage of knowing up front how much money you're going to have so that you can plan accordingly for that year for outlays—the small differentials that we've been talking about in terms of the use of the preceding year's data.

Mr. **Kildee**. I guess we're weighing two values, one being certitude, and the other expansion of the program. I think maybe with the increasing aging of America that expansion is a high value, and I am hesitant to exchange the possibility of expansion and new sites for certitude. Both have values, but I'm wondering whether we're in the mode right now where certitude is more important than the possibility of expansion.

Ms. **Crow**. Well, certainly, there are a lot of different factors that one would have to weigh. But under the per meal reimbursement rate you may be expanding and you may be serving more meals, but ultimately you are going to hit the appropriation limit. So it may turn out that you're going to get less per meal, and you may have regretted expanding because you are not going to get the full set reimbursement because by law the Secretary of Agriculture cannot give you more than is appropriated. So it may turn out that, in expanding, you basically undercut the stability of your own program. And so we think that the ability to know in advance and plan, perhaps get resources from other measures, perhaps use more commodities that the Department has available rather than to use cash, would all be positive aspects. And we have had, as I am sure you have had, discussions with local providers, and we think that there is a lot of popular support for the use of a grant and the use of up-front certainty.

Mr. **Kildee**. We haven't had that much problem Congressionally in the past on that. One or two years ago, I recall, I sponsored a bill for a supplemental because we found out that there wouldn't be a sufficient number of dollars for the people being fed. No one questioned whether people were hungry or not or needed to be fed, but we went to the Appropriations Committee and we received Hosanna in the Highest, you know, great welcome there; and they had no problem at all giving us a supplemental for that.

Getting back to my basic point, certitude is a virtue. And expansion, where we are right now in this country, is a virtue, and I think there might be a chilling effect on the expansion of programs under your present proposal. It might give them certitude, but a little hesitancy as to expansion. And I guess this committee would have to decide what is the higher value of those two, certitude or expansion.

Ms. **Crow**. Well, I think certainly, Mr. Chairman, that there are a range of priorities here. But we live in an age where our resources under the Federal system, as you all know and have to deal with every day, are scarce. It is not always possible to have supplementals. There are many programs that call for the expenditure of public funds. We think that under this proposal people would know what they had to look forward to every year. You think back; that is a great benefit in this type of program.

Mr. **Kildee**. I understand that. We have to be fiscally responsible, but at the same time, the amount of money that I went after 1 or 2 years ago wasn't even a blip on Cap Weinberger's screen over there. He didn't even protest. OMB made their protest, but they didn't come over here and throw their body in front of the door on it. It wasn't that much money, really, when you look at the total dollars. These are nutrition programs for elderly people. It's a high priority in the Nation and certainly a high priority in the Congress, a high priority in this authorizing committee, and a high priority in the Appropriations Committee. I walked in there and they were very nice to me when we asked for that money because they felt this was a good program. It's not a program where there are scandals; it's not like overcharging for an Allen wrench. We don't find the scandals in this program that you find over across the river in the five-sided building over there. It's really a very well-run program, and you're to be commended for that, really. It's a very well-run program.

Ms. **Crow**. Well, we give the States and the locals all the credit for how well run a program it is, and it's certainly an important program. But in terms of basically standing in line in the future for supplementals as a way to view this program, I think it's important, Mr. Chairman, for you and members of the committee to keep in mind that unlike many other programs that the Department administers that involve feeding, this is one where there is no means test for the people who have the benefit of this. The wealthiest person in town can come and partake and is welcome, as is the poorest person in tow. And I think when we're starting to look at the use of Federal funds, as we must all do very carefully, those feeding programs that are focused on needy people and that are means-tested, I think, in a sense have a certain priority on all of us. And I think this is an important consideration as well when we are arraying, as you say, the certainty versus the program expansion mechanisms.

Mr. **Kildee**. Well, there's no question that there's a good mix at these centers. I've been there. But to go back to the old saying, "Even the wealthy have the right to sleep under a bridge," there are probably more poor people sleeping there than wealthy.

I think one of the virtues of the program is that it is not a welfare program. In my city, it's really great to see a nice social mix there. I think that has some value, real value. And they can make a contribution, those who are able if they want; and that very often is the case. I don't find any real abuse at all in that social mix. As a matter of fact, I think it's a very positive part of the program, an extremely positive part.

But your program on the Federal level and the program on the local level is a very efficient program. It has a great reputation here in the Congress, and I think that was one of the reasons why, when I went before the Appropriations Committee, that they said, sure; this food is not being wasted. It's pretty carefully watched. It's got a good reputation.

I am hesitant to exchange this ability for expansion for some certitude.

Mr. Grandy?

Mr. **Grandy**. Thank you, Mr. Chairman.

Ms. Crow, I am new to this committee and I am new to this program and the intricacies contained therein, but I do represent a State that has had a disproportionate increase in elderly people over the last few years, and I guess I want to pick up a little bit on what the chairman said.

Do I understand that we're talking about roughly $140 million for 1988?

Ms. **Crow**. Yes.

Mr. **Grandy**. And that is based on the number of meals that were served in the previous year. In terms of what you're asking this committee to consider, that would be your figure, your grid over which we would disburse these dollars? Is that correct?

Ms. **Crow**. Well, the $140.3 million that is specified in the legislation is a fixed amount of money. How that money would be divided up amongst the States and then ultimately given to the local providers would be based in terms of percentages on the number of meals served within the State for the preceding year.

Mr. GRANDY. That's my point. Given the fact that your elderly population is increasing and that more people are eating these meals, it may not address the need for the present year that you're appropriating the funds for. That's my concern; there's no attempt to create a rolling average over a 5-year period to get a percent of increase so that you might correctly calculate the number of elderly that you would be serving in the year you are appropriating the funds for. You're just going back to the previous year; is that correct?

Ms. CROW. Yes. And that's based on discussions, in fact, with local providers and the feeling that that was the most relevant, and certainly the most current data, that we have available. In fact, that data is so current that at the beginning of the next fiscal year we still would not have all the numbers in for the preceding year, and we would have to make one slight adjustment, probably in February or March of the next year, to make sure that we have the exact number of meals. But that is, in fact, the most current and the most relevant data that we would have available to us. And as the Chairman has said, certainly there is a slight tradeoff between what is happening immediately and what happened last year; but we think that the advantages of the certainty of knowing how much money we're going to have, rather than have the potential—which is a very real potential—of a per meal rate reduction, we think the certainty far outweighs the downside.

Mr. GRANDY. I'm concerned, again, that given this method of calculation, that there would be a certainty that enough meals would be served. But I am following up again on what the Chairman was talking about.

You have a figure here that says that in fiscal year 1986, 96 percent of the subsidy was provided in cash.

Ms. CROW. That's correct.

Mr. GRANDY. So you had 4 percent in surplus commodities. Is that correct?

Ms. CROW. It is 4 percent in entitlement commodities. In addition, bonus commodities were provided as well. In fact, we are hoping that over time in this program there will be increased use of commodities as opposed to receipt of cash.

Mr. GRANDY. Are those commodities figured into the State allotment, into the appropriation? Do they have a dollar value?

Ms. CROW. Yes, they do.

Mr. GRANDY. Is that acquisition cost or market value? Do you know?

Ms. CROW. I believe that is acquisition cost by the Department of Agriculture.

Mr. GRANDY. That's good to know because that would expand their value. But given the fact that there's such a disproportion between cash and commodities, would you be encouraging the States, perhaps, to use more of the commodity programs which we have a lot of, as opposed to cash, which we have less of?

Ms. CROW. Yes, indeed. Those are both very real and very correct statements. The Department has very actively been working with providers within the Nutrition Program for the Elderly the past several years to try to increase the use of commodities. In fact, we have gone to some lengths to modify our policy in terms of the receipt of commodities to encourage that by reducing the threshold for States to receive bonus commodities, and this is all by way of saying that we think that commodities are a good bet. People are concerned—and you were talking earlier about stretching your food dollars. Our studies indicate that if you use commodities in place of the cash, you definitely do stretch your food dollars. We think they are a very good value, and we would like to see increased usage of commodities in this particular program.

Mr. Grandy. Well, the surplus commodity programs are widely used in my area, and fortunately, not just by elderly folks.

You said something about reducing the threshold for surplus commodities. I'm not sure I follow what you mean.

Ms. Crow. Well, I think I was using too much shorthand. Let me see if I can reconstruct really what I was trying to say.

In prior years the policy in the Department has been that if the State is to receive what are called "bonus commodities," and the word basically means what it is; it doesn't count against your entitlement, whether it was cash or commodities, but a bonus or a "freebie" in a sense. In order to be eligible for bonus commodities other than dairy commodities, in the past, your State, if you were the local provider, had to receive 50 percent or more of your entitlement in commodities rather than in cash. Many States, in fact, receive no commodities; they receive 100 percent in cash. Last year, in June of 1986, the Department changed its policy to reduce the threshold from 50 percent down to 20 percent to make commodities more easily available and more attractive to the States.

So if the State elects to receive only 20 percent in its entitle commodities, then it has available to it the full array of bonus commodities that the Department of Agriculture has to provide. And this, over the past years, has become increasingly more attractive. We've had ground beef which has been a part of the bonus system, as well as other fruits, vegetables, cherries, all kinds of very valuable and very useful commodities.

Mr. Grandy. How have the States responded to the reduction of that threshold?

Ms. Crow. We have had an increased number of States elect to receive their 20 percent level in commodities, so we think that we're definitely heading in the right direction. It's something that we are working with the States and the local providers on, on a very active basis, to try to make States and local providers aware of what commodities can do for them.

Mr. Grandy. Can you tell us how many States are now——

Ms. Crow. Yes, I believe I can.

Mr. Garnett, do you have that list?

Mr. Garnett. Yes.

Eight States have increased their use of commodities as a result of our policy.

Mr. Grandy. I'm trying to save dollars and get rid of some of the surplus grain in my State. I hope you'll understand that.

Ms. Crow. Yes, indeed, and certainly there's no question that from one limited point of view, the lower you make it the more people are going to obviously take advantage of bonus commodities.

If it were a zero threshold, obviously more people would use the bonus; but in turn, they wouldn't use the entitlement commodities. And the Department of Agriculture has to, in weighing priorities as you all do, keep in mind the advantages to the farm economy as well. So we think it's very important to continue some rational, reasonable threshold of entitlement commodity usage. And we think 20 percent is a good balance between encouraging the use of more commodities but keeping an intelligent level of commodity requirement per State. Otherwise we would be too severely dismantling our own commodity system and not assisting American farmers.

Mr. GRANDY. I'm just wondering if, in States with a high density of elderly population, there could be some kind of leeway for those States to perhaps reduce their threshold to avail themselves of more commodities and perhaps address the need that I talked about earlier, rather than spending money on them, getting some of those bonus commodities to help with that escalating number of elderly that would be eating these meals. Would the Department be disposed toward any kind of State lever like that, or an option to perhaps reduce your threshold if they have an increase in their elderly that is perhaps above the national average?

Ms. CROW. I think the Department spent a great deal of time in determining the original 20 percent threshold, and there is a great deal of merit on a national program to keeping equivalencies among States, because there are so many variables and so many factors that each State could say that would militate in favor of lowering the commodity threshold for that State. But it's important to keep in mind that the threshold is at the State level, but that doesn't mean that every single provider has to have 20 percent. It's possible that there's a vast mix within the State, so a provider that had a rural area with a particularly large concentration of elderly could, in fact, increase its usage of commodities to a substantial degree assuming that some other provider, perhaps, in another setting didn't want as many commodities.

So there's a lot of flexibility once you get to the 20 percent threshold within the State. There's a wide mix that is available. In fact, some providers within States take all of it in commodities and some take 100 percent in cash.

Mr. GRANDY. Thank you for talking me through that.

Mr. Chairman, I believe my time has expired.

Mr. KILDEE. Thank you, Mr. Grandy.

I believe it was last year that Mr. Tauke and I sheltered through a bill to raise the authorization for this program, and in that bill we encouraged greater use of the commodities, too.

Ms. CROW. We appreciate that, Mr. Chairman.

Mr. KILDEE. Do you mind if I call on the ranking minority member first?

Mr. SAWYER. You're the chairman, Mr. Chairman.

Mr. TAUKE. Mr. Chairman, I appreciate that; but since I didn't have an opportunity to hear the testimony or the questions, I don't want to be presumptuous.

Mr. KILDEE. OK.

The other side, Mr. Sawyer?

Mr. SAWYER. Thank you very much, Mr. Chairman.

Let me go back to the question that the chairman raised about certitude. I don't want to talk about expansion necessarily, but rather about service in general.

In the fixed grant versus per meal proposal that you've offered us, what happens when a State undergoes a disproportionate reduction in the numbers of meals served in any given year?

Ms. Crow. Well, if there was a reduction, then that is not going to be felt until the second succeeding year, in the sense that the grant would be based on the preceding year; and then if, within the year they actually receive the grant, their level went down, they would have a modest increase in the amount of cash available to them because we wouldn't really be thinking about per meal rates anymore. They could do what they would with that cash. They could spread it around any way that they want to, so they would be slight winners in that particular year that they receive the grant because, actually, the amount of people that perhaps they were serving or the type of food they were providing, the costs went down. In the next year, though, since we would have to continue to keep records on a per meal basis so we could determine the percentage share within each State, then the effect of that year would show up in the next year.

Mr. Sawyer. Well, from a governmental point of view they might win in that they would receive a substantially greater reimbursement per meal from Federal funds than they would otherwise. But in fact, would that not be a disincentive to provide the fullest possible service, even in that setting where there was a reduced number of meals served?

Ms. Crow. We think that the disincentive is when you don't know what's going to happen. It's like when you're going to have a party. You don't know how many guests are going to show up and you don't know how many groceries the grocer is going to deliver, but somehow you're going to have a party, and you don't figure out whether it was a success or not until all the guests go home. That's pretty much the situation that providers are in. And I think they can figure out what they want to do with their program every year if they know how much money they have, then they can determine their own activities within that particular year—how they spend their money, the kinds of food that they provide, the kinds of activities that they want, either soliciting more people or less people. They can manage their money, and we think the ability to do that far outweighs the slight dislocations and exactitude that you would have if you looked at it on a per meal basis. You wouldn't be looking at it that way anymore.

Mr. Sawyer. Maybe I don't understand. I thought that the purpose of the fixed grant proposal was to tell them how many people were going to come, and how much, therefore, they were going to be reimbursed.

Ms. Crow. I'm sorry if I gave you that impression, Mr. Sawyer. You wouldn't be telling them how many people are going to come——

Mr. Sawyer. How many meals will be served?

Ms. Crow. No, you wouldn't even tell them the number of meals. All you would tell them is how much cash they have to manage, and it will be up to them to determine the number of meals that they are going to serve out of that cash and the number of people, because under a grant you would really not have to think anymore in terms of a per meal reimbursement rate. Just view it as a fixed pot of money; it's yours; you receive it; do what you want with it. If you want to serve a lot more people with it and have, in a sense, less expensive meals, you can do that. If you want to have specialties in your meals, you could do that. It would be totally up to you to manage your program. We wouldn't be keeping a ticker tape, a counter at the door to see how many people walked in and how many people walked out.

Mr. **Sawyer**. Except now the analogy is that you're telling the States to give a party, but you're only giving them so much money to give the party with, and they don't know how many people are coming or how many people are not.

Ms. **Crow**. They don't know that right now. And on a per meal fixed reimbursement rate, they don't even know how much of that rate, up to the maximum permitted by the law, they're going to get until about 5 to 6 months after the end of the year. So it's like saying 5 to 6 months after your party is over, you'll find out if you have enough money to pay the grocer.

Mr. **Sawyer**. Well, I suppose that's the same problem that we face today.

Let me ask you this. I think we all had a sense that Congressman Hammerschmidt was going in the right direction in seeking to build an outreach program that would not just deal with one arena of service, but try to reach out across a number of service sectors that deal with older Americans. Do you have any sense of how that proposal, if enacted, would interface with the kind of very specific limitations—in the interests of economy—that the fixed grant proposal would have on States, especially those that were very successful in that kind of operation?

Ms. **Crow**. Mr. Sawyer, quite honestly, I have not had a chance, nor has anyone to my knowledge in the Department, had a chance yet to review Congressman Hammerschmidt's proposal. We'd be more than pleased to do that and provide you a response at a later time to your question. I just feel it would be somewhat presumptuous of me to try to speculate right now on whether there would or would not be an interrelation.

Mr. **Sawyer**. Thank you very much.

Ms. **Crow**. Thank you.

Mr. **Sawyer**. Thank you, Mr. Chairman.

Mr. **Kildee**. Mr. Tauke?

Mr. **Tauke**. Thank you, Mr. Chairman.

Do we have any information that would tell us what level of expansion we are experiencing from year to year in the individual States?

Ms. **Crow**. We certainly have data, trend data, over the past number of years that would explain what is happening.

Mr. **Tauke**. Nationally, we're serving more meals?

Ms. **Crow**. Yes—well, it varies. Going back, say, to 1982, there has been approximately a 6 percent per year increase in the program, except that in 1986 there was a 1-percent increase in the program. So you can't say with absolute specificity what is taking place.

Mr. **Tauke**. But generally we've had an expansion?

Ms. **Crow**. There has been a modest expansion.

Mr. **Tauke**. Do you know if, say, one State has had a 15 percent expansion and another State has had a 2-percent shrinkage—what would be the parameters on a State-by-State basis? Do we have that information?

Ms. **Crow**. Well, I'm sure that we certainly have that data. I don't know if we have it available to discuss with you today.

No, we don't have it with us today, but certainly we do have that type of State trend data.

Mr. **Tauke**. Perhaps that could be helpful to us in determining how much differential there is from State to State. That information might be helpful in letting us know whether or not some States would be at a great disadvantage under this kind of program.

I will tell you that I think the people in my State are anxious to have something like this; they are anxious to have some certainty at the beginning of the year, by knowing how much money they are going to have to manage the program. We have had some very unfortunate circumstances in the past, as you know, which I know has caused providers in my State, and in my home area, to be reluctant to do anything that would bring more people into the program, which is the opposite of what we want.

In your proposal while there is no incentive for expansion in the sense that you will get more money this year, obviously if you expand you'll get more money next year. So in that sense, there is an incentive for expansion.

Do you think it would be feasible to have some kind of separate appropriation, one percent or something of the fund, that could be used to cover outreach efforts or expansion? Some kind of effort to deal with the expansion part of the program?

Ms. **Crow**. Quite honestly, we haven't considered that. Certainly, we'll be pleased to discuss it with you. But just as a general policy matter, the Department believes that the money is best spent in putting food on the table, and I think that certainly we would hope that the funds would be spent on those types of activities.

Mr. **Tauke**. Under your proposal do you put any restrictions on what the State can do with the money?

Ms. **Crow**. Currently, as the bill is drafted, the money goes to the State, and then it is the State option as to how it handles the funds that it receives. It certainly is our intent that what the State will do is then, in turn, give local providers their proportionate share of the amount of money based on the meals that each local provider served the preceding year.

Mr. **Tauke**. But theoretically the State could reserve some money for new sites?

Ms. **Crow**. Well, the State would be required to pass all of the money to the local providers under a specific provision in the bill. We are not interested in having the State take any portion of it for administrative expenses.

Mr. **Tauke**. Just for theoretical purposes, suppose we had three providers, and each served an equal number of meals last year. But the State said, Provider number 3 is not completely serving the area and the population covered by that provider, so therefore we want provider number 3 to open another site and we expect that we will see more meals served by provider number 3.

Would the State have the flexibility to give more money to provider No. 3 than providers No. 2 and 1, even though the previous year they had served equal numbers of people?

Ms. CROW. As the law is currently written, yes, they would.

Mr. TAUKE. Well, I think you've given us some interesting ideas, and we'll look forward to working with you to see if we can make this a proposal that can satisfy all of the concerns that members of the subcommittee have.

Ms. CROW. Thank you.

Mr. KILDEE. You have been helpful in trying to help us weigh this certitude/expansion because we're still groping with that ourselves. You've been very helpful on that.

Under your bill if you expand this year, then next year you can get some extra money. I guess the question is, where do they get the money to expand this year, though? If more people are coming for meals, where do they find the money to feed those people in the current year? They really can't wait until next year, for that. From the private sector, perhaps? Maybe from the State or local government? I guess that's the question we have to ask ourselves, where would they get the money in the current year?

In a State strapped for dollars, as in the midst of a recession which my State of Michigan unfortunately goes through from time to time, the private sector generally is not a good source for those dollars, and the public sector—State and local government—is usually strapped for dollars, too.

So I guess the question I have is would they be able to expand within that year in the hopes—expectation, I should say—that they would get money the following year? But they can't really buy the food in the current year for the greater numbers who would be coming to that center.

So I think those are the things we'll be wrestling with. You've been very helpful on that.

Let me ask you this. Suppose we did this—I'm just brainstorming a bit here, suppose we took your proposal, and permitted up to a certain percentage of expansion—you might think that over.

Ms. CROW. Well, I have some difficulty with it, because it just assumes that all sites in all States are going to expand on a uniform basis.

Mr. KILDEE. No, they'd have to show expansion. Last year, up to a certain percentage of expansion. If they didn't have any expansion, they wouldn't get it. Up to a certain percentage.

Ms. CROW. Well, we would certainly be pleased to try to discuss this with you outside of the confines of this particular hearing.

Mr. KILDEE. Sure. I understand; you want to reflect upon that. We'll be back and forth with you.

Ms. CROW. Certainly. We appreciate that, Mr. Chairman.

Mr. KILDEE. Your testimony has been excellent. It's been very helpful, and we look forward to working with you as we develop this reauthorization bill. Thank you very much.

Ms. CROW. Thank you.

Mr. KILDEE. Our next group will consist of a panel. I'm going to call them in the order in which they'll testify because one person has to catch a plane. They'll testify in this order: William R. Hutton, Executive Director, National Council of Senior Citizens, Washington, DC; Eugene I. Lehrmann, board member, American Association of Retired Persons; Mr. Donald F. Reilly, senior vice president, the National Council on the Aging, Inc.; Samuel J. Simmons, president, National Caucus and Center on Black Aged, Inc., Washington, DC.

We welcome this panel before this committee. You can testify or summarize; your entire written testimony will be included in the record immediately following your oral presentations. We will take you all, and then we will open up for questions at that point.

Mr. Hutton?

STATEMENT OF WILLIAM R. HUTTON, EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. HUTTON. Thank you, Chairman Kildee. I would like to take advantage of your offer to insert the entire testimony, and perhaps in order to tighten up the whole deal, if I can just take some of the highlights.

Chairman Kildee, I really want to thank you for this opportunity to present our views on the reauthorization of the Older Americans Act.

In connection with title III—maybe I'll deal with that first—there are five areas that we'd like to address.

The first is the pressing need for more services for the frail elderly. The National Council of Senior Citizens strongly endorses the Chairman's proposal to expand in-home services, and believes these new funds should be used to provide care directly. A recent GAO report found that 1.3 million elderly persons do not get all the help they need with such activities as eating, getting in and out of bed, dressing, using the bathroom, preparing meals, or leaving home. There is a terrible shortage of available services. The Older Americans Act cannot and should not meet all these needs. For example, Medicare home health services must be expended, but OAA funds can support the provision of many in-home services vital to the independence and to the dignity of the frail elderly.

The second issue is the targeting of services to the low income and to the minority elderly. We are greatly disturbed that Administration on Aging data reveal a significant decline in participation by these vulnerable groups over the past 6 years, and we believe that the time has come for more explicit direction by Congress as to how targeting may best be delivered.

At the national level, we are concerned that the current funding formula may not provide adequate resources to those areas with the greatest need. We think that new funds over the fiscal year 1987 appropriated level should be allocated using a more sensitive formula which would include poverty, minority status, numbers of rural elderly, and the very old.

At the State level, the intrastate funding formula should be required to include these factors in allocating resources. Furthermore, we believe the States must evaluate and report on their success in serving these vulnerable groups.

Likewise, the Area Agencies should be accountable for how well they serve these most vulnerable, especially the poor, and document areas of unmet need in their communities.

Thirdly, we are concerned that there may be a conflict between the practice of soliciting fees for service and low income participation. Voluntary contributions for meal shave soared from $79 million in 1979 to $140 million in 1985. It is unknown whether this correlation is the sole—or even the most significant—reason for declining participation by low-income persons.

The National Council of Senior Citizens believes it is imperative that further study be conducted as to the potential impact of contributions on low-income participation. We think it would be a serious mistake to begin to impose new fees or voluntary contributions for supportive services, as some are advocating, until more complete information is available on the effects of current practice. Expansion of services must not be at the expense of low-income participation.

Fourthly, we'd like to see service providers play a greater role disseminating information about other programs for which seniors might be eligible; for example, food stamps; SSI; Medicaid, and energy assistance. This would certainly be a help in the suggestion which Representative Hammerschmidt made this morning.

Participation rates by the elderly poor in these programs is abysmally low. We believe the environment of the senior center or other community facility, combined with information and assistance, could make real inroads in helping older persons receive benefits for which they are eligible and which could enhance the quality of their lives.

In 1985, amendments to the Food Stamp Act were approved which actually require Social Security offices to provide information and assistance on food stamps to applicants for and recipients of SSI. Now, the U.S. Department of Agriculture must reimburse the Social Security Administration for the related expense, and we believe a similar arrangement could be applied to the Older Americans Act.

Finally, the National Council of Senior Citizens believes that the advocacy role of the OAA is one of its most important functions. We are disturbed that the 1985 regulatory overhaul of the act may have given a message to the aging network that advocacy is no longer important or, in some cases, acceptable.

The regulations state that advocacy efforts may not "supersede statutory or other regulatory restrictions regarding lobbying or political advocacy with Federal funds." But according to the Congressional Research Service, there appears to be no Federal statute specifically applicable to private recipients of Federal funds as to the lobbying of State or local governmental agencies or units when consistent with the purpose of the grant program. Congressional action could help clarify this issue.

Mr. Chairman, there's no program under the Older Americans Act of which we're more familiar or more proud than title V, the Senior Community Service Employment Program. As you know, the National Council of Senior Citizens has been a sponsor of title

V, which we call the Senior Aides Program, since its inception in 1968. I've been with it in that direction all of this time. For nearly two decades, title V has enjoyed tremendous popularity in towns and cities across the country and unparalleled bipartisan support here in Washington. Every independent study of the program, including one completed just last year under contract to the Department of Labor, has concluded that title V is meeting vital needs in the Nation; that it is cost-effective; and that it is well-managed and operated by the Department of Labor, the contractors and the States.

The success of the title V program can be attributed to its original concept, that low-income older workers have a vital role to play in meeting essential community services. It is neither a welfare program nor a make-work program. Senior aides work 20 hours a week and they are compensated at the Federal minimum wage or at the prevailing wage of the job performed. For most Senior aides, a modest salary of about $3,500 a year before deductions represents the difference between dependency on SSI, food stamps, and other public assistance programs, or sustaining a financially independent way of life. Equally important, they gain dignity, confidence, new job skills, and a tremendous sense of accomplishment from being engaged in useful work which contributes to the quality of life of the entire community.

As a result of severe cutbacks in the Federal, State, and local human service budgets in recent years, more and more cities and counties now rely heavily on title V participants to maintain such vital services as child and adult care, day care centers, shelters for the homeless, rape hotlines, centers for battered women and children, and soup kitchens for street people. They work in public hospitals to provide help for families and victims of Alzheimer's disease, and they are helping to fill the pressing need discussed earlier as providers of in-home care for the frail elderly.

For many older participants, the Senior Aides Program also represents the road back to full- or part-time work, unsubsidized by the Government. Our special training "EXTRAide Program," which is authorized by section 502(e) of the act, prepares older workers for jobs as office managers, even computer operators, bank tellers, word processors, and home health care providers. All title V sponsors have promoted job training and placement efforts in order to meet the Department's unsubsidized placement target of 15 percent. This year, DOL has set the goal at 20 percent; at NCSC we came very close to that last year. We are more than halfway there now, and we expect to be on target by June 30 with 20 percent.

Successfully accomplishing the goals of title V has been possible, I believe, because of the flexibility which has characterized the administration of the program by the Department of Labor. DOL has realized that the various sponsors—four of us are represented here—have different approaches to meeting program goals, and thus have given significant discussion in operation while insisting on strict adherence to all sections of the act and its regulations. The present administrative arrangement is one of the major strengths of the title V program; it's an arrangement which has succeeded, and I believe it should remain unaltered.

While there has been talk about problems in coordination throughout our nearly two decades of operating this program, NCSC has seen relatively few problems with respect to this issue of coordination and cooperation among any of the title V sponsors. We are in compliance with and will continue to work toward meeting the requirements of section 503(a) which mandates us to consult with State and area agencies regarding the location of projects and the assessment of community needs. That's an important area, that assessment of community needs.

In the area of equitable distribution, NCSC considers itself a leader in working with States and other national sponsors to assure that opportunities to participate in title V are fairly and properly disbursed to those most in need of jobs. We've launched new projects in some instances. We have reduced enrollment in others, and we have conferred and consulted with the governors and the State agencies at every possible opportunity. Similarly, we cooperate and coordinate with JTPA in the job programs across the Nation.

Thank you very much, Mr. Chairman. I will cut it off there, but thank you very much.

[The prepared statement of William Hutton follows:]

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1987 Reauthorization of the Older Americans Act

Testimony Presented Before the
Human Resources Subcommittee
of the House Education and Labor Committee

by

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April 6, 1987
Washington, D.C.

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Secretary-Treasurer, Jack Turner, Detroit, Michigan **General Counsel**, Robert J. Mozer, New York

Good morning Chairman Kildee and members of the Subcommittee. I am William R. Hutton, Executive Director of the National Council of Senior Citizens. On behalf of our members, I would like to thank you for this opportunity to present our views on the reauthorization of the Older Americans Act (OAA).

Over its 22-year history, the Older Americans Act has adapted and grown to address the changing needs of an aging population. It remains a vital avenue of service delivery and employment opportunity for millions of older persons. Like others who have come before this Committee, NCSC believes that no major restructuring of the Act is called for in this reauthorization. But we do recommend some fine tuning which would improve services for those who most need them.

We will direct our comments to Titles III and V of the Act.

Title III

Services for the Frail Elderly

There is a pressing need for more resources for Title III programs. During the past six years, OAA funding has been stagnant and has failed to keep pace with the demographics of an aging society. Not only are more persons living to be 65 and older, but the fastest-growing age group is comprised of those 85 and older.

Whereas 9.4 percent of the elderly were at least 85 in 1985, by 2010 this proportion will be nearly 17 percent--an increase of almost four million individuals. The very old are far more likely to be frail and impoverished than their younger counterparts, creating greater demand for costly services.

Another group of persons requiring more in-home care are those released early from the hospital as a result of the DRG system. For these persons, a short period of services may be all that is required. For those with chronic problems, in-home and community-based long-term care services can help them remain independent, preventing expensive and unnecessary institutionalization.

NCSC strongly endorses the Chairman's proposal to expand in-home services. We believe these new funds would be best directed toward provision of services. A recent GAO report found that 3.2 million elderly persons required assistance with such activities as eating, getting in and out of bed, dressing, using the bathroom, preparing meals or leaving home. But only 1.9 million said they got all the help they need from relatives, friends or household aides or health workers. The rest——nearly 1.3 million——said they need more help with basic activities.

Clearly, there is a terrible shortage of available services. The Older Americans Act cannot and should not meet all these needs. For example, Medicare home care services must be expanded. But OAA funds can support the provision of many in-home services vital to the independence and dignity of the frail elderly.

Targeting of Services

An issue of very great concern to NCSC is targeting of services to low-income and minority elderly. We are greatly disturbed that Administration on Aging data reveal a significant decline in participation by these vulnerable groups over the last six years. (See Appendix A.) In our opinion, the structure of the Act, which requires targeting to persons with the greatest needs yet prohibits the stigma of means testing, is excellent.

However, we believe that, in light of declining participation by poor and minority elders, the time has come for more explicit direction by Congress as to how targeting may best be achieved. Our recommendations address each level of the aging services network.

At the national level, we are concerned that the program's funding formula, which looks only at each state's share of the nation's population aged 60 and older, may not provide adequate resources to those areas with greatest need. We do not advocate any upheaval in current funding allocations. Rather, we think that new funds, over the FY 1987 appropriated level, should be allocated using a more sensitive formula.

By weighing a number of risk factors associated with greater need, we think OAA service delivery could be improved. These risk factors include poverty, minority status, numbers of rural elderly and the very old. The latter three factors are all associated with disproportionate poverty rates.

At the state level, we strongly believe the intrastate funding formula must be required to include these factors in allocating resources. Furthermore, we believe the states should evaluate and report on their success in serving these vulnerable groups.

Likewise, the Area Agencies should be accountable for how well they serve those most vulnerable, especially the poor, and document the areas of unmet need in their communities.

At the service provider level, outreach is already required and we believe such efforts should be directed toward the poor, be they frail, minority or rural elderly.

Fees for Service

The structure of the Older Americans Act currently allows service providers to solicit "voluntary contributions" for meals served. Such fees are useful to the extent that they expand the number of meals served and allow those with adequate resources to offset the Federal subsidy for the program.

There may be a conflict, however, between the worthy intent of a contributory system and its impact on participation by low-income seniors. Despite the requirement that services be targeted to those with greatest social and economic need, over the past six years, low-income participants have comprised smaller and smaller percentages of persons served. Concomitantly voluntary contributions have soared from $79 million in 1979 to $140 million in 1985.

It is unknown whether this correlation is the sole, or even the most significant, reason for declining participation by low-income persons. Low-income participation in the supportive services component of Title III has also plummeted, although fees are not now permitted for those services. But some anecdotal evidence from service providers has indicated that increased emphasis on contributions can deter participation by the poor, who are unable to afford higher fees.

The National Council of Senior Citizens believes it is imperative that further study be conducted as to the potential impact of contributions on low-income participation. We think it would be a serious mistake to begin to impose new fees or voluntary contributions for supportive services, as some are advocating, until more complete information is available on the effects of current practice. Expansion of services must not be at the expense of low-income participation.

Outreach

It is unfortunate that many service providers cannot meaningfully conduct outreach because they are already serving to capacity and maintaining waiting lists. We believe, however, that a very important service could be provided by the OAA network to those seniors who come into contact with these agencies. Specifically, we would like to see service providers play a greater role in disseminating information about other programs for which seniors might be eligible——for example, food stamps, SSI, Medicaid and energy assistance.

Participation rates by the elderly poor in these programs are abysmally low. Studies to date have singled out lack of information as the greatest factor in non-participation. None of these important programs reach much over one-third of the elderly poor.

We believe the friendly and non-stigmatizing environment of the senior center or other community facility, combined with information and assistance, could make real inroads in helping older persons receive benefits for which they are eligible and which could enhance the quality of their lives.

In 1985, amendments to the Food Stamp Act were approved which require Social Security offices to provide information and assistance on food stamps to applicants for and recipients of SSI. The U.S. Department of Agriculture must reimburse the Social Security Administration for the related expenses. We believe a similar arrangement could be applied to the Older Americans Act. This would allow expansion of vital services without causing financial hardship for the aging network.

Advocacy

NCSC believes the advocacy role of the OAA is one of its most important functions. We are disturbed that the 1985 regulatory overhaul of the Act may have given a message to the aging network that advocacy is no longer important or, in some cases, acceptable.

The regulations state that advocacy efforts may not, "supersede statutory or other regulatory restrictions regarding lobbying or political advocacy with Federal funds." This chilling language replaced provisions which called for the aging network to represent the interests of the elderly before state and local legislative and regulatory bodies.

NCSC believes this language should be restored. A 1985 memorandum prepared by the Congressional Research Service addressed this issue and found that, "There appears to be, in fact, no Federal statute specifically applicable to private recipients of funds distributed by Federal agencies as to the 'lobbying' of state or local governmental agencies or units by those private recipients when consistent with the purposes of the grant program." Furthermore, the memorandum notes that the well-known Office of Management and Budget (OMB) Circular A-122, which has been taken by many to prohibit all lobbying with Federal funds, in fact, says that grant recipients may use Federal funds for "any activity specifically authorized by statute to be undertaken with funds from the grant, contract or other agreement."

It would appear that lobbying state and local legislative and regulatory bodies is, in fact, already allowed, but we do not believe this is clear to the aging network. Congressional action could help clarify this issue.

Title V

Mr. Chairman, there is no program under the Older Americans Act with which we are more familiar or more proud than Title V, the Senior Community Service Employment Program. As you know, the National Council has been a sponsor of Title V——which we call the Senior AIDES Program——since its inception in 1968. As one of the three original sponsors, we have seen Title V grow from a $10 million demonstration project to a program that will provide employment opportunities to over 61,000 low-income older men and women this year.

The expansion of Title V over the past two decades reflects the program's tremendous popularity and importance in towns and cities across the country and its unparalleled bipartisan support here in Washington. Every independent study of the program--including one completed just last year under contract to the Department of Labor--has concluded that Title V is meeting vital needs in the nation; that it is cost-effective; and that it is well-managed and operated by the Department of Labor, the eight national contractors and the states. It would be very hard to find another Federal program that has received such positive and consistent comments after repeated studies. We at NCSC are very proud, as we are sure all other sponsors are proud, of this record. We have worked hard to make Title V what it is today and we continually seek ways to build upon past accomplishments.

The success of the Senior Community Service Employment Program can be attributed to its original concept that low-income older workers have a vital role to play in meeting essential community services. It is neither a welfare program nor a "makework" program. Senior Aides work twenty hours a week and are compensated at the Federal minimum wage or at an hourly rate commensurate with the prevailing wage of the job performed. Moreover, at NCSC, our staff monitors local projects closely and frequently to make certain that the jobs to which Senior Aides are assigned are meaningful and that they are responsive to well-identified community needs.

We are all aware that Federal, state and local human service budgets have suffered severe cutbacks during the past several years. In many cities and counties, the only resource available to maintain vital services or to initiate needed new services has been through the help of Title V participants. Seniors Aides have always worked in child and adult day care centers, in libraries, in nutrition programs, in outreach and referral centers, in fire and crime prevention programs, and in transportation projects which help local seniors to get to their doctors, pharmacies and grocery stores.

In recent years, however, we have seen Senior Aides also working in shelters for the homeless, in centers caring for abused children, in food banks aiding disadvantaged people of all ages and in soup kitchens providing hot meals for street people. They are helping to fill the pressing need discussed earlier as providers of in-home care for the frail elderly. They work in public hospitals to provide help for families and victims of Alzheimer's Disease and, in several locations across the country, Senior Aides operate highly successful job placement services for young people as well as other older workers.

While the services that Senior Aides provide are clearly vital in their communities, we should not overlook the benefits which the older workers themselves derive from participation. First, they earn a salary; on average $3,500 a year before deductions. For most enrollees, this represents the difference between dependency on SSI, Food Stamps and other public assistance programs or sustaining a financially independent way of life. Perhaps equally important, they gain dignity, confidence, new job skills and a tremendous sense of satisfaction and accomplishment from being engaged in useful work which contributes to the quality of life of an entire community.

For many older participants, the Senior AIDES Program also represents the road back to full or part-time employment, unsubsidized by the government. In 1987, for the sixth consecutive year, the National Council of Senior Citizens was authorized to conduct special training designed to prepare older workers for jobs in the private sector. The "EXTRAide Program" provided under Section 502(e) of the Act, prepares older workers for jobs as building managers, computer operators, bank tellers, word processors, child care and home health care providers.

All the Title V sponsors have promoted job training and placement efforts such as these in order to meet the Department of Labor's unsubsidized placement target of 15 percent. This year, DOL has set the goal at 20 percent. At NCSC, we came very close to that goal last year; we were more than halfway there at the end of the second quarter this year, and we expect to be on target on June 30th. Together with the other Title V sponsors, we will continue to stress to private employers, to public and nonprofit agencies, and to anyone else who will listen, the value of the experience, maturity and reliability which older workers bring to their jobs.

Successfully accomplishing the goals of Title V——jobs for older workers with limited incomes, meaningful and useful community services and placement into unsubsidized employment for many——has been possible and continues to be because of the flexibility which has characterized the administration of the program by the Department of Labor. DOL has realized that the various participants in the program may have different approaches to meeting program goals, and, thus, has given significant discretion in operation to the several sponsors. While affording flexibility, DOL has also insisted upon strict adherence to all sections of the Act, as well as the Federal regulations. The present administrative arrangement is one of the major strengths of the Title V Program; it is an arrangement which has succeeded and should remain unaltered.

Although there has been much talk about problems in coordination throughout our nearly two decades operating this program, NCSC has seen relatively few problems with respect to this issue among Title V sponsors. We are in compliance with and will continue to work towards meeting the requirements of Section 503(a) of the Older Americans Act, as amended, which mandates us to consult State and Area Agencies on Aging with regard to the location of needed projects and the assessment of community needs to be met by such projects. We also adhere to DOL requests by cooperating and coordinating with the JTPA and Job Corps programs across the nation.

The effective application of this provision can be evidenced in the area of equitable distribution, a focus of legitimate concern in recent years. Although we have yet to completely alleviate the problem, NCSC considers itself a leader in working with states and other national sponsors to ensure that opportunities to participate in Title V are fairly distributed and available to those most in need of jobs. We have launched new projects in some instances; we have reduced enrollment in others; and we have conferred and consulted with appropriate state agencies at every opportunity.

In truth, some of the most innovative projects we administer today were borne out of equitable distribution goals. Two years ago, no Title V sponsor was addressing the growing needs of the low-income Asian community in Los Angeles. With the help of increased funding and by transferring resources from "over-served" regions in California, NCSC founded a Chinatown Senior AIDES project. Working in cooperation with the Chinese Committee on Aging, this Title V project is meeting the varied needs of the non-English speaking Asian community. Senior Aides work as interpreters in Social Security offices, police stations, community service agencies and in the Superior Court. They staff literacy programs, employment services, crime prevention programs and work in senior nutrition and housing sites. NCSC operates a similar project in conjunction with the Chinatown Planning Council, Inc., in New York City.

Taking steps to meet the unique needs of the Hispanic community has also been the result of equitable distribution. Our

Bakersfield, Oxnard and East Los Angeles projects now employ nearly 300 Senior Aides, virtually all of them of Mexican descent. Many of these older workers are also bilingual and work as translators at homeless shelters, rape hot lines, legal service offices and health clinics. These Senior Aides staff child day care centers and after-school youth programs, permitting single mothers to get jobs instead of public assistance. They work in Alcohol and Drug Abuse projects, in literacy programs and, as trained teacher aides, help high school dropouts pass their GED exams.

In both of these cases of increasing employment opportunities and needed services in underserved communities——as in similar examples throughout the country——the State of California was fully informed of our efforts and pleased with the results. We do not see a need for additional statutory directives or bureaucratic steps to ensure progress toward equitable distribution. We have made great strides and will continue to do so wherever feasible. At the same time, we hope this Committee will concur with NCSC's position that no eligible, low-income senior, now gainfully employed in the program, should be laid off under this directive.

Bringing administrative costs to a minimum while maintaining a competent staff and assuring the integrity of the program has been a consistent objective among all the administrators of Title V. While we share the concern of the other sponsors that the impending 12 percent limit will create problems for some, we continue to take pride in an administrative rate that is projected at barely ten percent this year. We urge this Committee to continue to permit flexibility on the part of the Department of Labor, and believe a good deal of time would be saved in reviewing requests for exceptions if the administrative limit could be returned to 15 percent or, at the least, 13.5 percent. In this regard, we are especially concerned about those national contractors whose services are directed primarily toward minority groups. These sponsors do not have the economies of scale that NCSC and other large contractors have.

Today, more than ever, older workers need employment opportunities. Although increasing numbers of senior citizens want and need to reenter the labor force, long-term unemployment among workers 55 and over remains disproportionately high. A Congressional Research Service study, published last April on Displaced Older Workers, found that while workers 55 and over were 18.4 percent of all displaced workers, they represented just 11.3 percent of all displaced workers who had found new jobs. The study noted that "given their relatively high unemployment rate (31.8 percent), it appears that the 55-64 age range group had the most difficulty upon losing their jobs. Black workers in this age group, with an unemployment rate of 57.6 percent, seem to have had an especially hard time in the labor market."

As we have said, NCSC is particularly concerned that Older Americans Act programs are adequately targeted to low-income and minority seniors, as well as the growing frail elderly population. In the case of the Senior Community Service Employment Program, this service priority is already being addressed.

As the only means-tested program under the Act, all Title V workers have incomes below 125 percent of the poverty line, or $6,875, and 77 percent have incomes below the poverty line. Further, approximately 40 percent of NCSC Title V enrollees are minorities. Finally, more than half of all the older workers in the Program are employed in services assisting other older Americans.

The Title V senior jobs program remains the only major government response to the needs of older workers. Yet, this modest employment program enrolls less than one percent of an estimated eight to ten million seniors who are willing and able to work. Beginning July 1, 1987, Title V will return to its FY 1985 funding level of $326 million; sufficient funds to support approximately 63,800 part-time jobs. While all other programs under the Older Americans Act have, once again, received increases in appropriations this fiscal year, Title V funding has remained stagnant for some time.

Mr. Chairman, while some Federal programs may warrant significant structural or administrative adjustments to bring about improvement, in the case of Title V, we have a time-tested, successful program which has consistently proven its worth. Recognizing the vital need for this program and the tremendous contribution Title V workers are making in their communities, we urge this Committee to reauthorize Title V for a minimum of three years. Moreover, the National Council of Senior Citizens strongly recommends that the 1987 reauthorization of the Older Americans Act provide sufficient growth in the Title V program to afford more low-income older persons the opportunity to participate and remain productive and self-sufficient members of their communities.

Thank you.

APPENDIX A

Executive Director
William R. Hutton
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President
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Targeting of Older Americans Act Services

CONGREGATE MEALS

	1981	1982	1983	1984	1985
Total # of Meals	143 m	140 m	145 m	147 m	150 m
Total # of Persons	2.8 m	2.8 m	3.2 m	2.9 m	2.9 m
Greatest Social Need	1.3 m (46%)	1.4 m (50%)	1.5 m (49%)	1.6 m (54%)	1.6 m (54%)
Greatest Economic Need	1.7 m (60%)	1.7 m (61%)	1.8 m (56%)	1.6 m (56%)	1.6 m (53%)
Minority	535,000 (19%)	501,000 (18%)	591,000 (19%)	496,000 (17%)	475,000 (16%)

HOME-DELIVERED MEALS

	1981	1982	1983	1984	1985
Total # of Meals	45 m	51 m	58 m	67 m	75.5 m
Total # of Persons	568,000	517,000	611,000	611,000	693,000
Greatest Social Need	361,000 (64%)	370,000 (72%)	390,000 (64%)	431,000 (71%)	483,000 (69%)
Greatest Economic Need	372,000 (66%)	349,000 (67%)	370,000 (61%)	388,000 (63%)	447,000 (64%)
Minority	109,000 (19%)	103,000 (20%)	115,000 (19%)	114,000 (19%)	120,000 (17%)

SUPPORTIVE SERVICES

	1981	1982	1983	1984	1985
Total # of Persons	8.9 m	9.1 m	9.2 m	9.1 m	9.3 m
Greatest Social Need	3.7 m (42%)	4.1 m (44%)	4.3 m (47%)	4.5 m (49%)	4.4 m (47%)
Greatest Economic Need	4.5 m (51%)	4.7 m (52%)	4.7 m (51%)	4.3 m (47%)	4.0 m (43%)
Minority	1.6 m (18%)	1.7 m (18%)	1.6 m (18%)	1.6 m (18%)	1.5 m (16%)

m = million

Source: Administration on Aging, Summary of Program Performance

First Vice President, Dr. Mary C. Mulvey, Providence, Rhode Island **Second Vice President**, George J. Kourpias, Washington, DC
Third Vice President, Dorothy Walker, Detroit, Michigan **Fourth Vice President**, Everett W. Lehmann, Washington, DC
Secretary-Treasurer, Jack Turner, Detroit, Michigan **General Counsel**, Robert J. Mozer, New York

Mr. Kildee. Thank you, Mr. Hutton. I appreciate that. I know you have to leave soon, but I wanted to thank you and your staff for helping me develop the amendment to title III for the frail elderly, the $25 million. The good news is that the Budget Committee, in Function 500, gave as one of its reason for expansion, the need to help the frail elderly.

Mr. Hutton. That's very good. I do support it absolutely, and I do hope it will succeed.

Mr. Kildee. Thank you very much.

Mr. Lehrmann?

STATEMENT OF EUGENE I. LEHRMANN, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Lehrmann. Good morning, Chairman Kildee, members of the committee, ladies and gentlemen. I am Gene Lehrmann from Madison, WI, a volunteer serving on the Board of Directors of the American Association of Retired Persons. On behalf of the association's more than 24 million persons, I would like to outline some of the trends in aging in America and share with you some of our recommendations in regard to the reauthorization of the Older Americans Act.

In order to foster maximum independence, the mission of the act has been to provide a range of services to those older people with the greatest economic and social need. Everyone is aware of the rapid growth in the Nation's older population; by 1980, the number of persons over 55 had increased by 141 percent, and those 65 and over by 183 percent. By the year of 2035, one in every five will be 65 years of age and over. As the older population has increased there has been a substantial shift in the sex and racial composition. Older women now outnumber men three to two; by 1990, 11.3 million women 65 and older will be single and living alone. That's compared to 8 million today. Although older minorities will continue to comprise a smaller group in absolute numbers than older whites, their numbers are increasing at a faster rate.

Major changes in public policy are essential to cope with these trends in aging. Today there are about 20 persons 65 years and older for every 100 persons of working age. After baby boomers turn 65 around the year 2030, however, this ratio is expected to double. Such changes will have a significant impact on the provision of adequate housing, health, social services, employment, and social security since there will be fewer workers to support publicly funded programs for older persons.

The Older Americans program can respond to the needs of this changing older population by focusing on health and long-term care, employment opportunities and income maintenance, housing, and coordinated social services that assist older persons in coping with their independent living needs. This means that the act should continue to target special populations while providing sufficient flexibility to State and local agencies to meet local needs.

The following are some of the specific recommendations that directly affect the most vulnerable and disadvantaged elderly persons.

AARP believes that needed improvements in the act would facilitate better service to all the Nation's elderly population. AARP strongly believes that the legislation should be extended for at least 3 years, and that the aging agenda should be elevated within HHS by having the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

To maximize the benefits derived from each AAA dollar, AAA's should be required to reaffirm their commitment to a coordination/facilitation/advocacy role. It also seems appropriate that AAA's should be involved in cancer care management only as a part of a carefully controlled demonstration that includes a broad array of other nonprofit entities besides AAA's. AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. The Association believes that the current allocation formula has served its usefulness. A more effective allocation formula should be phased in over the length of the next reauthorization of the act.

AARP continues to support a policy of voluntary contributions for service. We recommend that no broad for-fee service plan be adopted prior to a carefully monitored demonstration where the impact on minorities and low-income elderly populations can be ascertained.

The Association urges stronger statutory language to promote minority participation. Minorities should be based on their need, and I emphasize need rather than their proportion of the total population.

The Commission should be given the discretion to withhold some reasonable sum from the State where it consistently fails to meet modest goals in the State plans on service to elderly minorities.

AARP believes that legal services for older persons should be reauthorized as a priority service with at least 6 percent of the funds appropriated under title III–B being expended for each priority service.

The association recommends a number of changes to strengthen the ombudsman's direct roles in consumer protection. They are detailed in the full text of our testimony. However, AARP opposes an extension of ombudsman authority into home health care services at this time.

Mr. Chairman, because of time constraints I would like to refer the committee to our recommendations. These range from redesignation of planning and service areas to gerontology centers, title V and interagency coordinations with those of the act.

In conclusion, AARP urges prompt reauthorization of the Older Americans Act. Our suggested changes to the act and its administration require little statutory change but greatly improve services for all other Americans, older Americans as well.

The elderly of our Nation deserve our most careful attention to this important legislation. Larry White of our staff is here to assist me on questions later on, Mr. Chairman.

[The prepared statement of Eugene Lehrmann follows:]

AARP

TESTIMONY

OF

EUGENE I. LEHRMANN

ON BEHALF OF

THE AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

U.S. HOUSE COMMITTEE ON EDUCATION & LABOR

SUBCOMMITTEE ON HUMAN RESOURCES

REGARDING

REAUTHORIZATION OF THE OLDER AMERICANS ACT

APRIL 6, 1987

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TESTIMONY OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT

PRESENTED BY JOHN DENNING

Good afternoon Mr. Chairman, Members of the Committee, ladies and gentlemen.

I am Eugene I. Lehrmann, Member of the Board of Directors of the American Association of Retired Persons. On behalf of the Association's more than 24 million members I would like to outline some trends in aging in America, and share with you some of our recommendations regarding reauthorization of the Older Americans Act.

For over twenty years, the Older Americans Act has served as the sole federal social and community service statute designed exclusively for older persons. In order to foster maximum independence, the mission of the Act has been to provide a range of services to those older persons with the greatest economic and social need. As Congress deliberates the many issues of reauthorization under the Act, it is important for the aging community and policy makers to consider demographic and social trends in aging. This will allow us to frame our policy recommendations not just around immediate needs, but also the needs of older persons in the future.

Size and Growth of the Older Population

Everyone is aware of the rapid growth in the nation's older population. What is startling about the aging trend today is the rapid pace. In the last two decades alone, the 65 and over population grew by 54 percent while the under 65 population increased by only 24 percent. In 1940 there were just over 20 million persons 55 years of age or older and about 9 million over age of 65. By 1980, the number of persons 55 and over increased by 141 percent and those 65 and over by 183 percent.

Increases in these two populations pale when compared to increases in the oldest age groups, those 75 and over. The number of persons 75 and over has increased by more than 275 percent between 1940 and 1980. This trend is expected to continue into the next century. By the year 2035 every fifth American will be 65 years of age and over.

As the older population has increased, there has been a substantial shift in its sex and racial composition. Since 1940, women 55 and over constitute a greater proportion of the older population. The survival rate for women at age 65 is 30 percent greater than men of the same age. As a result, older women now outnumber men three to two. Census projections indicate that by 1990 there will be 11.3 million women 65 and older who will be single and living alone, compared to approximately 8 million today. These changes will have a great impact on the demand for income supports, social services, and health care.

The increase in the number of older minorities has also contributed to the significant growth in the older population. The number of older persons who are members of minority groups has increased faster than the number of older white persons. By the year 2025, the portion of older persons who are minorities is projected to increase 75 percent compared to a 62 percent increase for the white population. Older minorities, however, will continue to comprise a smaller group in absolute numbers than older whites.

Major changes in public policy will be essential to coping with the effects of the changing numbers in different age groups. Presently, there are about twenty persons 65 years and over for every hundred persons of working age. After baby-boomers turn 65 around the year 2030, however, this ratio is expected to double. Such variations in the dependency ratio will have a significant impact on the provision of adequate housing, health and social services, employment, and social security due to the decline in the number of workers to support such publicly-funded programs for older persons.

The Older Americans Act program can respond to the needs of this changing older population in a variety of ways:

o Health and Long Term Care

As the incidence of frailty, disability, and chronic illness increases in a growing older population, the OAA can play an important role in the development of a comprehensive coordinated system of health and long term care services. While most older persons are somewhat healthy and active in their early retirement years, health and mobility decline with age. Important issues for the future will have to focus on health service needs and cost containment, including services designed to help older persons function within their own homes.

The problems associated with rising health care costs will continue perhaps beyond this century. As this occurs, we need to pay equal attention to access and quality of health and medical care.

o Income Maintenance

The provision of adequate income for older Americans is one of our greatest challenges. An adequately funded and expanded Title V program is essential to meet the employment needs of older Americans. While there is a growing perception that the economic status of older persons has improved significantly, when the cash income of the elderly is compared to that of the young working population, there remains a substantial discrepancy. While the proportion of elderly poor has dropped by two-thirds since 1959, our future concern must focus on how to meet the public costs of income maintenance for older persons given the increased older population, expanded longevity, and inflation. In order to stretch limited resources we must continue to focus on building public and private program structures that increase retirement income opportunities, particularly those serving older persons with lower incomes.

o Housing

Few issues will be more important to the future well-being of older people than their living environments. Adequate supportive service programs under the Older Americans Act such as homemaker, friendly visitor, and chore services are essential to prevent premature institutionalization of many older persons. Expanding and strengthening such services will be essential to a properly designed housing policy in the future and may contribute in saving public resources expended on older persons. Current demographic projections indicate that the number of households headed by older persons is steadily increasing. More than one-fifth of all U.S. households are headed by persons 65 and over and this figure will rise by 33 percent in 1995. As the proportion of older persons increases, particularly the frail elderly, the dominant issue will be how can we design and implement interventions to assist older persons in coping with their housing and independent living needs.

o Social Services

Much of our success in meeting the future needs of our older population will lie in our ability and willingness to strengthen provisions under the Older Americans Act. As funding for social service programs declines in the face of increasing demand, the Older Americans Act, as the focal point for federal assistance to older persons, becomes even more critical. The present system is plagued by fragmentation, duplication, and ineffective coordination efforts at all levels. Increasing life expectancy will have major implications for the way we must revamp our human service delivery systems. Coordination will be critical if we are to adequately address the needs of older persons in extremely varied circumstances and with varying levels of need. This means that the Act should continue to target services to special populations while providing sufficient flexibility to state and local agencies to meet local needs.

The following are some of our specific recommendations that directly affect the most vulnerable and disadvantaged elderly persons. AARP believes these needed improvements in the Act would facilitate better service to all of the nation's elderly population.

Extension of the Older Americans Act and Heightened Visibility of the Administration on Aging

AARP strongly believes that the legislation should be extended for at least three years. This would enable service providers and others to make long-range plans and to chart their activities more effectively. Morever, it would still allow appropriate congressional committees to perform oversight responsibilities. Also, because many programs have operated with no increased funding or cuts, AARP will continue to advocate adequate funding for all programs under the Act, especially those targeted to vulnerable populations. This could be achieved through authorization of such sums as necessary.

The Older Americans Act and subsequent amendments make clear that Congress intended the Administration on Aging (AoA) to be a highly visible and strong advocate for the aged. However, AoA is currently a subunit along with several other agencies (such as the Administration on Children, Youth, and Families or the Administration on Developmental Disabilities), within the Office of Human Development Services at the Department of Health and Human Services (HHS).

The net impact is that AoA has not fulfilled its intended role because of its lower status in the HHS organizational structure. We strongly believe that the aging agenda should be elevated within HHS by having the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

Advocacy, Coordination, Facilitation, and Care Management Roles of Area Agencies on Aging (AAAs).

The role of Area Agencies on Aging (AAAs) as service providers by contrast to their role as facilitators/coordinators and advocates is a major concern of the Association. Congress recognized when the law was enacted that there would always be insufficient funds under the OAA to serve all eligible elderly persons. In order to maximize the benefit derived from each OAA dollar, AAAs should be required to reaffirm their commitment to a coordination/facilitation/advocacy role. The current requirement to justify direct provision of services to older persons in the state plan needs stronger emphasis, and more attention needs to be placed on coordination, facilitation and referral. Although there may be a need in some situations for AAAs to assume the role of service providers, use of OAA funds for service delivery should not take priority over the ability of AAAs to perform the coordination mandate of the Act.

AAA involvement in case or care management should be considered only in the context of the above comments and recommendations. Additionally, it should be noted that in situations where the AAAs become the direct deliverers of service, there is great potential for conflict of interest between their marketplace provider role and their statutory role to facilitate, monitor, and advocate.

In light of these concerns, it seems appropriate that AAAs be involved in case or care management only as part of a carefully controlled demonstration that includes a broad array of other non-profit entities besides AAAs. The exception would be where other providers (private and non-profit) are not responding to the need for services.

The demonstration sites should be selected on a competitive basis. Each demonstration applicant should submit a plan for activities and intended outcome. Periodic evaluation of plan implementation and outcomes would be required. Demonstration costs should not exceed a specified reasonable amount.

Opposition to Consolidation of Funding for OAA Programs

AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. Further, the Association opposes consolidating funds of different programs under the same Titles within the Older Americans Act. For example, we favor separate authorizations for (1) supportive services and senior centers, (2) congregate meals, and (3) home-delivered meals. We fully recognize that a single authorization would make it easier for state and local offices on aging to submit funding plans. It would also provide great flexibility for offices on aging. However, these "administrative convenience" arguments are outweighed by other considerations. First, separate authorizations for supportive services, congregate meals, and home-delivered meals enable these programs to maintain greater visibility. This, in turn, has produced more realistic appropriations, especially for the nutrition program.

Second, there is already flexibility to shift funds under Title III. For example, 30 percent of the funding for the nutrition program for the elderly can be transferred to supportive services and senior centers, and vice versa. Moreover, up to 15 percent of the nutrition appropriations can now be shifted between congregate meals and home-delivered meals. AoA approval is required if a larger percentage is needed. In fact, there has already been a significant transfer of Title III funds.

Third, consolidation of OAA program funds with other OHDS monies or consolidation of program funds under the Act itself makes services to older persons more vulnerable to a block grant. This would certainly mean less funding to services for older Americans, and especially aged minorities. For example, before elimination, only a tiny fraction of revenue sharing funds were used for services for the elderly. In addition, block-granting is usually a prelude to program cuts. With ever increasing numbers of older persons, cuts could not be more ill-timed.

Redesignation of Planning & Service Areas

In order to avoid jurisdictional disputes and possible service disruptions, AARP questions the adviseability of any proposal to expand the authority of AoA and the states to redesignate planning and service areas. Ample authority already exists to change planning and service area boundaries when necessary.

Opposition to Raising the Age for Allocation of Funds Without Taking into Account the Needs of Special Populations

An allotment formula is used in computing the amount of federal money each state will receive under the OAA. Any proposal to raise the population threshold for allotment of funds under Section 303 from age 60 to age 70 should take into account the service needs of special populations (such as minorities, frail elderly persons, and the rural elderly poor) who do not meet the arbitrary age threshold for the allocation of funds. A formula change which targets additional funds to states with higher concentrations of persons over 70 as proposed by the Administration, may be justified because of the increased costs in serving this group. However, the Administration's proposal, unless modified, would set a dangerous precedent for ignoring the real health, nutritional, and social needs of those in their sixties who are presently served. Not only does this create an inconsistency by having a formula based on 70 when the program serves persons at age 60, it ignores the special needs of minorities who depend more upon services to the elderly between ages 60 and 70 and statistically do not have a 70-year life expectancy. Although those minorities reaching age 70 typically live as long as the general population, inadequate health and other factors in earlier years contribute to lower life expectancies. Our concern should focus not only on those who manage to survive to age 70, but to assure that as many as possible live as long as possible. Indeed, need for service should be the factor weighted most heavily in any effort to revise the allocation formula.

The Association believes that the current formula for allocation has served its usefulness and we should begin exploring new alternatives that reflect future realities of aging. A more effective allocation formula would weigh four criteria. Highest weight would be assigned to economic need, followed by social need (minority and age 75+), then rural, and finally those over age 60. Such a formula should be phased in over the length of the next reauthorization of the Act and should include a hold harmless clause for funding to states. This would ensure that no state suffers cuts but redirects any new funds to areas of need. Intra-state allocations should also reflect this formula change.

Finally, 35 states would lose money under the age 70 based formula until 1991 when most are expected to approach or slightly exceed current funding levels. Given the demand, our emphasis should be to reverse this negative association between funding and growing need.

Fee-For-Service Under the Older Americans Act

The proposal that states and AAA's be given the option to set sliding scale fees for service raises concern about the following:

(1) voluntary contributions or mandatory payment for services;

(2) payment based on income; and
(3) adequacy of current cost sharing contributions mechanisms.

AARP has traditionally supported voluntary contributions emphasizing non-aggressive solicitation of contributions from those who could afford to pay. State and area agencies believe that a sliding scale fee would permit coordinating OAA program services with other services that are means-tested in some way. There would be no fee for referrals, outreach, advocacy and Ombudsman services. What is not clear is which services (e.g., health, transportation, homemaker, legal, meals, chore on companion) would be subject to contributions and how the rates would be set. There should be protected groups that would be exempt from fees such as those with incomes less than 125% of the poverty standard. Unfortunately, some evidence suggests that declining participation by minority and low income populations results from a perception that a voluntary contribution is actually a charge for service.

AARP continues to support a policy of voluntary contributions for service. We recommend that no broad fee-for-service plan be adopted prior to a carefully monitored demonstration where the impact on minorities and low income elderly populations can be ascertained. In such a broad, multi-state demonstration, emphasis should be placed upon non-aggressive solicitations, self-reporting of income, and no direct or indirect coercion. Solicitations for contributions should occur after the service is rendered, and consideration should be given to exempting the contributions requirement altogether for legal services. Even then there should be uniformity among the states as to which services are exempt from contribution, although states should have the option to charge a fee for nonexempt services. Only after we have devised ways to ensure fair fees that do not deter those most in need should the policy be expanded to a national one.

Minority Participation under the OAA

Due to the dramatic decrease in minority participation rates in OAA programs, the Association urges that stronger statutory language should be incorporated in Title III to promote increased participation by aged minorities in services programs. Older minorities receive about 18 percent of services under Title III of the Act. But their participation rate is nearly twice that level in the Title V Senior Community Service Employment Program (SCSEP). In fact, minorities constitute about 40 percent of all Title V enrollees. Minority participation rates under Title III have declined every year except one from FY 1980 to FY 1985.

Findings of the 1982 Minority Elderly Services Report by the U.S. Civil Rights Commission concluded that while older minorities participated to some extent in all Title III programs, there were some services where minorities were consistently absent. Minority persons often felt that OAA programs were not responsive to their needs and priorities; meals were not culturally appropriate; non-English publications were seldom available; and there was insufficient publicity about OAA programs and referral services. Outreach to minority older persons by AAAs was poor, and minorities were absent or excluded from the service delivery planning process on local advisory councils. A final reason for lower minority participation was the failure of state offices on aging to monitor the civil rights compliance of local offices on aging. The Commission report noted underrepresentation of minority contractors under Title III and low status for minorities working in AAAs.

AARP believes that the OAA should require state plans to include reasonable assessments of aging minority needs. Moreover, they should be served on the basis of their need for service rather than their proportion of the overall population. State Units on Aging and AAAs should engage in appropriate outreach efforts to include liaison with community organizations concerned with the needs of minority elderly persons. Additionally, the Association urges that the OAA should require federal, state, and local offices on aging to take affirmative steps to promote opportunities for minority employment, training, and contracts. The aging services network, we firmly believe, will be more effective in responding to the special problems and challenges confronting older minorities if more minorities are employed in decision-making positions and as service providers. More bilingual personnel should be hired to serve limited-English-speaking older persons.

Documentation of efforts to serve older minorities should also be required. The Commissioner should be given the discretion to withhold some reasonable sum from the state where it consistently fails to meet modest goals outlined in the state plans on service to elderly minorities. The Commissioner would then contract for services to targeted minorities or authorize the state to contract for such services.

Finally, it is essential to encourage more minorities to enter the field of aging because there is a dearth of adequately trained minority professionals and para-professionals in gerontology.

Legal Services Under the Older Americans Act

Older persons not only have the same legal service requirements as most other Americans, but also have additional need for legal services due to their unique health, income, and social status. Older people are often dependent upon services provided by large government bureaucracies using complex and often changing regulations, guidelines, and procedures. Affordable, competent legal assistance is critical to their ability to obtain basic necessities such as health care, in-home support services, protective services, or other benefits. Legal problems of elderly persons may also relate to discrimination in the workplace, a landlord-tenant controversy, or other disputes which may require judicial intervention.

AARP believes that legal services for older persons should be reauthorized as a priority service under the Older Americans Act. Because many AAAs provide little or no legal services to older persons, the law should be amended to require at least 6 percent of the funds appropriated under Title III (B) to planning and service areas be expended for each priority service. The establishment of at least 6 percent of Title III (B) money would restore legal services funding to its FY 1980 level. However, maintenance of effort language is necessary for programs currently spending more than 6 percent. It should be clear that 6 percent is not to be interpreted as a ceiling.

The Congress should also authorize a private right of action for procedural violations of the Act. This private right of action should extend to both service providers as well as program beneficiaries.

Under the current law, violations of the Act cannot be redressed in court since the courts have held that there is no implied cause of action or standing for affected parties. Without the ability to sue in court, an older person has no effective redress when, for example, an area agency illegally charges for meals under the Title III nutrition program, or fails to provide legal assistance within its planning and service area. Similarly, without standing in court, a legal services provider cannot sue a state for its failure to provide an administrative hearing in a situation where a local area agency had failed to provide legal assistance in its jurisdiction.

AARP further recommends authorization of a study to determine compliance with priority service requirements. The Secretary of the Department of Health and Human Services must enforce the Act with regard to priority services. In 1975, Congress authorized a study to examine the effectiveness of prioritizing services under the Act. The study revealed that prioritization did focus more money upon access, support, and legal services, but that legal services remained least favored among the three programs.

The Association supports Reauthorization and funding of Section 424 of the Act which authorizes national legal services support and demonstration projects operated by national non-profit legal assistance organizations. AARP further recommends a separate authorization of $1 million for the the work of national legal assistance organizations mentioned in 424 (a)(1) of the Act. Also the scope of 424 (a)(1) services should be expanded to serve legal assistance providers as well as state and area agencies.

National Legal Services support centers (such as the National Senior Citizens Law Center) provide training, support, and backup to lawyers who represent older clients. Assistance ranges from case consultation and legal advice to the development of training materials and programs for lawyers and paralegals.

Better Coordination of Services to Native Americans and Indians

AARP recommends that older Native Americans should also be served under Title III when such services are not duplicated under Title VI. It is vital for older Indians and other Native Americans to receive services under the Act through whatever mechanisms most efficiently meet their legitimate needs. Any view that Title VI, because it is targeted exclusively to Indians, should be the sole source of service to elderly Native Americans overlooks the needs of those off reservations who cannot be reached by tribal services. This proposal would also eliminate inequities resulting from overlap and administrative complications between Titles III and VI under the Act.

Strengthening the Ombudsman Program:

Ombudsmen play critical roles as consumer advocates for the nation's 1.5 million nursing home residents. Although there are ombudsman programs in every state and territory, their effectiveness varies widely. AARP believes that increased federal funding and stronger federal leadership is necessary to ensure the efficacy of this important program.

A number of changes are necessary to strengthen ombudsmen's direct roles in consumer protection. Not only state ombudsmen but their designees, such as local and volunteer ombudsmen, should be granted 24 hour access to nursing home and board and care facilities. With the approval of the resident or his/her representative, they would have the same access to residents and their records. Reprisals against residents or employees who file complaints should be strictly prohibited. Further, legal representation should be authorized for ombudsman programs and for ombudsmen who are the subject of legal action as a result of "good faith" effort to do their jobs. The federal government also needs to provide strong support for the establishment of ombudsman training and technical assistance programs at state and substate levels.

In addition to aiding individual residents, ombudsmen can be important conduits of information to regulatory agencies and to public officials. Mechanisms should be developed to ensure that state licensing and certification agencies (and where appropriate, PROs) consider data on problems of quality identified by ombudsmen. They would also share with ombudsmen such information.

The Older Americans Act makes ombudsmen responsible for advising public officials on the effects of laws and regulations on nursing home residents. This responsibility, however, can be interpreted as conflicting with OMB circular A-122 which prohibits federally funded programs from lobbying. Ombudsmen, including substate ombudsmen, should be exempted from the anti-lobbying provisions of this circular.

AARP opposes an extension of ombudsman authority into home health care services at this time. Ombudsmen have indicated that they do not have the resources to undertake an effective monitoring and advocacy role in this area. An extension of ombudsman authority into home care would jeopardize current work in nursing homes, as well as the expansion into board and care facilities that was authorized in 1981 but remains almost entirely unfulfilled.

Finally, a study on mechanisms to ensure the quality of care in nursing home, board and care, and home health settings should be undertaken. It should include, but not be limited to, representatives of consumers, providers, the Congress, HCFA, the Administration on Aging, and the AAAs. The study should include an analysis of quality control methods used in similar settings, i.e., those used with the mentally retarded/developmentally disabled.

Specialized Long Term Care Research, Education, and Training Centers

Our nation needs to build a much stronger base for research, education and training on community-based long-term care. As a step in that direction, AARP supports the authorization of funding under Title IV for up to 10 such specialized centers. The centers would be funded on a competitive basis for 5 year intervals. Centers would be evaluated yearly. Reapplication would be encouraged where evaluations show effective, innovative, and efficient operation. This would prevent costly and harmful service interruptions while assuring that effective performance is recognized. We envision at least the following criteria in the implementation process:

A. Applicants would include such entities as institutions of higher education, public agencies such as State Offices on Aging and AAA's, and non-profit organizations.

B. The centers would be focused topically, not by region, to support the development of comprehensive, coordinated community-based service systems and service delivery methods (including family support), to provide training and technical assistance in such methods, to support community education on long term care, to engage in research, education and training in close collaboration with community agencies including, but not limited to, agencies funded under the Older Americans Act. Center activity should focus on services designed to support alternatives to institutionalized living and the assessment of need, the development and coordination of plans of care, linkage among institutional (including hospital) and non-institutional providers, and family support.

C. Center activities should emphasize interdisciplinary and intergenerational approaches to service delivery and training and should include projects addressing the needs of special populations, including but not limited to the indigent, the oldest old, persons with Alzlheimer's disease and related disorders, the disabled persons, minorities, and rural elders.

Coordination of OAA with Programs for the Disabled and American Veterans

The elderly population is extremely diverse and has problems that are addressed by a broad array of federal and state agencies and programs. Frequently programs and agency administrators fail to maximize their effort on behalf of their client population due to lack of coordination. Two such areas of insufficient coordination on behalf of older persons by the aging network are veterans and the disabled. The Association supports coordination of services between programs under the Older Americans Act and programs serving veterans and disabled persons. AARP recomends that the Act be amended to reflect this clarification of the law.

Coordination should be encouraged between the aging network and the disability network generally, and should not be limited merely to coordination with the developmental disabilities network. The term "developmentally disabled" refers to mental and communications disorders whose onset occurs prior to adulthood. Therefore, those persons whose disabilities occur late in life would be excluded from the "developmentally disabled" population. We recommend, therefore, that language authorizing coordination of services should be broad enough to include all disabled persons, regardless of when their disabilities occurred.

In light of limited funds under the OAA, we recommend that coordination of services be permissive and not mandatory at this time. Since no one is sure exactly how many otherwise eligible disabled persons would require services under the OAA, we recommend that coordination be authorized initially on a discretionary basis. Similarly, more coordination of programs by AoA and those provided for veterans should be encouraged.

Concerns About Title V

Currently, sponsors under Title V (Community Services Employment for Older Americans) have a 13.5 percent administrative cap. This cap is unreasonably low given the high cost of placing senior workers in unsubsidized jobs. Among National Sponsors, unsubsidized placements is directly correlated with administrative cost. AARP believes that reinstating the 15 percent administrative cap would increase the number of elderly persons placed in unsubsidized employment. It would also help to ensure that national contractors expand job development activities. As a national sponsor, AARP has recently placed 45.5 percent of its enrollees in unsubsidized jobs. This was by far the best performance among national sponsors. However, the lower cap may jeopardize this placement record by forcing consolidation of projects and curtailment of job development acitvities. This could result in loss of employment opportunities for present and potential enrollees.

Another major concern of the Association about Title V is the inadequate level of service to Native Americans. Although Title V targets low income and minority populations, older Native Americans continue to be the least served population both in terms of numbers and level of need. The National Indian Council on Aging cites a poverty rate exceeding 60 percent for older Indians. The Administration on Aging and the Department of Labor should be directed to make a determination of how to best meet the employment and training needs of older Native Americans in a comprehensive strategy. Since certain minority groups are represented by at least one national sponsor under the Act, serious consideration should be given to directing proportionate increases in Title V funding to the creation of a national sponsor for Native Americans.

1991 White House Conference on Aging

In order to focus attention on major issues of importance to older persons, the 1991 White House Conference on Aging should emphasize a unifying theme. This will enable policy makers, the aging community, and the public to better assess the present status of older Americans and to propose comprehensive solutions for the future. AARP endorses the theme "Maintaining Independence" for the 1991 Conference. It would address six areas: economic security; long term care; opportunities for a longer worklife; affordable health care; community building with intergenerational resources; and those left behind who are the most vulnerable populations.

Conclusion

As the aging population grows, greater demands are placed on the social service system. Therefore, an aging network that responds effectively to the needs of older persons is vital. Improved access to existing programs under Title III of the Act; expanded responsibilities of the state ombudsmen in protecting our older citizens in their living environments; improved legal services; better research, training, and demonstrations in the field of aging; and more fiscally responsible coordination and administration of programs serving the elderly should be the priorities of reauthorization.

AARP urges prompt reauthorization of the Older Americans Act. Our suggested changes to the Act and its administration, although requiring little statutory change, will help to greatly improve services for all older Americans. The elderly of our nation deserve our most careful attention to this important legislation.

TESTIMONY ON BEHALF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS REGARDING REAUTHORIZATION OF THE OLDER AMERICANS ACT

PRESENTED BY EUGENE I. LEHRMANN

EXECUTIVE SUMMARY

The Association strongly supports the Older Americans Act (OAA). It should continue to target services to special populations while providing sufficient flexibility to state and local agencies to meet local needs.

AARP believes the legislation should be extended for at least three years, and authorized at such sums as necessary. The Commissioner should report directly to the Secretary rather than to the Office of the Secretary.

Sometimes AAAs have to assume the role of service providers, but use of OAA funds for service delivery should not take priority over the coordination mandate of the Act. AAAs should be involved in case or care management only as part of a carefully controlled demonstration that includes a broad array of other non-profit entities besides AAAs.

AARP opposes consolidating funding for OAA programs with funds for other programs within the Office of Human Development Services. Further, the Association opposes consolidating funds of different programs under the same Title within the Older Americans Act.

Any proposal to raise the population threshold for allotment of funds under Section 303 from age 60 to 70 should take into account the service needs of such under 70 groups as older minorities, frail elderly persons, and the rural poor. The Association also urges that stronger language should be incorporated in Title III to promote increased participation by aged minorities.

Legal services for older persons should be reauthorized as a priority service under the Older Americans Act with a requirement that at least 6% of Title III (B) money be spent on each priority service. Congress should also authorize a private right of action for procedural violations of the Act, a study to determine compliance with priority service requirements, and reauthorize Section 424 of the Act.

The Association recommends that no national fee-for-service plan be adopted prior to a carefully monitored demonstration being implemented and evaluated to determine impact on the neediest older populations.

Service to older Indians under Title III should be more accessible. Similarly the Administration on Aging and the Labor Department should devise a more effective strategy for meeting the enormous employment needs of older Native Americans.

The increased number of individuals receiving institutional care necessitates an expansion of the role of the Ombudsman to permit more effective monitoring and advocacy on behalf of older persons. AARP opposes an extension of Ombudsman authority into home health care services at this time. However, the Association does endorse authorization of specialized centers for long term care research, education, and training.

AARP supports reinstatement of the 15% administrative cap for national sponsors of Title V senior employment programs to encourage job development, increase unsubsidized placements, and prevent termination of program enrollees.

The Association also supports statutory changes that encourage coordination of the Older Americans Act programs with programs administered by other agencies, especially programs for the disabled and American veterans.

The Association further recommends that a 1991 White House conference on Aging be held with a single unifying theme to focus attention on the more critical issues of aging trends in America.

Mr. KILDEE. Thank you very much, Mr. Lehrmann.

Mr. Donald F. Reilly.

STATEMENT OF DONALD F. REILLY, SENIOR VICE PRESIDENT, THE NATIONAL COUNCIL ON AGING, INC.

Mr. REILLY. Mr. Chairman, our full statement is submitted for the record also.

First, we recommend the reauthorization for 4 years, which recognizes both the growth in population of the elderly, and also projections of inflation.

Next, we'd like to address some serious concerns that NCOA has with regard to title III. I think the best way to get to those concerns is to quickly sketch in the evolution of title III.

The enactment of the Older Americans Act in 1965 was a timely response to the emerging needs of the first sizable number of retired persons in our history and the growth in numbers of the older population. We knew little in 1965 about the life changes that accompany retirement from the work force; we knew less about the potential of this new group for volunteer service and community service employment. Social isolation was a newly discovered phenomenon. The frail elderly were not yet identified as a growing subgroup of the older population, but it was already clear that older persons as a group had significant needs for services and opportunities and that this population and its needs would continue to grow.

During the 22-year period since enactment, older persons have grown rapidly in total number. During this period the Older Americans Act and the programs operated through its funding have continued to evolve. Originally under title III, State Agencies on Aging made seed money grants to senior centers and other community service agencies for the start up and expansion of community services. The act was amended to have Area Agencies on Aging designated by State agencies. The role of each area agency is to provide leadership to all organizations which serve, or should serve, the needs of older persons, and to fund selected service providers toward development of "comprehensive and coordinated service systems to serve all older individuals" within its multicounty, county, or city planning and service area.

The act was subsequently further amended to have area agencies "designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers as such focal points."

Provisions for the development of long-term care, ombudsman, and legal services were also added.

The 1984 reauthorization added further area plan requirements to "facilitate the coordination of community-based long-term care services designed to retain individuals in their homes and designed to emphasize the development of client-centered case management as a component of such services."

We believe that each of these elements contributes to the comprehensive service delivery system needed in each community. The consistent intent of these incremental amendments has been to increase the accessibility of services to older persons who need them and to reduce fragmentation of services in order to assure that service delivery is coordinated to meet the specific needs of the individual older person.

The National Network on Aging has responded to this intent. It is made up of 57 State agencies, 670 area agencies, over 10,000 senior centers, and approximately 8,500 other service provider agencies, augmented by approximately 87,000 volunteers in national voluntary agencies. Its primary focus has been on preventing dependency by combatting social isolation and loneliness, providing social services, and providing opportunities for older persons to remain active in their communities. This focus is expanding to include services to the rapidly growing number of frail older persons in their communities. The change had begun prior to 1984, but the pace has been accelerated by the 1984 amendments, State concerns about rapidly rising Medicaid costs which lead to State targeting initiatives for title III, and the general lack of program funds to serve the seriously impaired who are not residents of nursing homes.

The service needs of severely impaired older persons frequently require a mix of health care and social services. These services are much more labor-intensive, which raises the cost, whether in group settings or in the home. When delivered in the home, the one-on-one nature of these services further raises the cost. As the network moves into this area in a period of rare funding increases, serious issues arise that could change the basic nature of the Older Americans Act in undesirable directions.

The first problem with the increasing number of impaired older persons in our communities, their families, and the title III network are confronted by is the lack of a national policy on long-term care. By default, Medicare has become the major funder of institutional long-term care. It was not designed for that role. Neither Medicare nor Medicaid is designed to be a major funder of community long-term care, whether in-home or community-based congregate services. Thus, other than out-of-pocket costs by impaired older persons or their families, the services are paid for by an unstable combination of Medicaid, Medicaid waivers in States which have such waivers, the title XX social services block grant, title III of the Older Americans Act, and State and local funds. The combination varies from State to State and community to community.

The need for in-home and community-based long-term care and services is growing rapidly. The natural growth resulting from the increasing numbers of the "old old" is being accelerated by the "sicker-and-quicker" hospital discharges resulting from the Medicare prospective payment system.

As the States search for more money to meet these needs, the Older Americans Act title III-B funds are a tempting target because they are flexible and have low State and low matching requirements. These pressures have resulted in an increasing number of State and local targeting initiatives which tend to restrict title III-B services to the frail elderly. Some proposed amendments to the act would move in the same direction.

We disagree with this movement because it will incrementally turn title III-B into a health care-oriented community long-term care adjunct to Medicare and Medicaid, with funding completely inadequate to the role.

We believe that the answer to the need for health-oriented community long-term care systems is to be found in proposals such as H.R. 65, introduced by Congressman Pepper. It would create a Medicare Part C, funded by a tax, to pay for these necessary services. This approach would provide a guaranteed funding base, make community long-term care an entitlement for those who need it, and avoid means testing.

If legislation of this type cannot be enacted this year, then we favor interim measures to generate substantial additional funds, such as liberalizing the current Medicare home health regulations and policies and making the Medicaid section 2176 waiver provisions available to all States.

The title III program has made a substantial investment in the development of service delivery systems providing congregate, preventive, and supportive services in communities across the Nation. Information and referral, counselling, health screening and education, legal and financial counselling, home repair, special transportation, congregate meals, group activities, support groups, and volunteer projects which serve others can help maintain independence and prevent or delay a future need by many older persons for inhome services, adult day care, or institutional long-term care.

Senior centers and other agencies providing these services should remain an integral part of the title III continuum of services or we will weaken the service continuum at one end while attempting to strengthen it at the other end.

We also oppose any increase in the age range covered by the Older Americans Act since it would be another move to reduce preventive services.

It is in the area of in-home services and congregate programs for the frail where social services and health services come together in blends which are still evolving. Adult day care is a rapidly increasing service which provides social day care for impaired older persons. Some agencies specialize in providing day care for older persons whose impairments require periodic health or health-related services. This type of service is usually called "day health care." Public policy has not yet clearly addressed the appropriate funding sources for each type and the line of demarcation between them.

Some older persons confined to their homes can be maintained by home-delivered meals, friendly visiting, telephone reassurance, and chore services. Some also need homemaker services. Others also need home health aid; others need more intensive medical services. How Medicare, Medicaid and title III funding should come together in this area is not resolved and is a major problem in terms of the use of title III-B funding.

The National Association of Area Agencies on Aging reports that its member agencies are already spending a disproportionate percentage of their funds on services for the frail home-bound person. We believe that this reauthorization of the act should make it clear that title III funding for in-home and adult day care should be limited to those services currently nonreimbursable through Medicare, such as long-term assistance with personal care, homemaking, shopping, and so forth, so that a balance should be maintained between preventive and maintenance services, and that a new funding source is needed for medically oriented community long-term care.

Another issue is related. The flat funding in recent years while the size of the older population has been growing and the number of severely impaired persons in the community has been increasing has generated proposals for authority to impose mandatory sliding scale fees for service.

The philosophy of the Older Americans Act from the beginning has been that no means test would be imposed, though voluntary contributions could be sought. This important principle should be retained. The introduction of complex bureaucratic rules and procedures to set fees by income level would be a major step into means testing and a diversion of limited service dollars into administration.

The third issue is that the general cutbacks and capping of domestic programs have caused some groups who advocate for special populations to consider seeking special funding set-asides within the Older Americans Act.

The system-building role of State and area agencies includes reaching out horizontally to other service systems, such as mental health, developmental disability, and the blind. It also includes assuring that the needs of older persons are considered in the development—all older persons, that is—are considered in the development of area service plans. However, the title III-B funding is too limited to make special set-asides a feasible pattern. This does not conform to the principle of local funding flexibility.

We also have several specific recommendations for title III content. We recommend that section 306(A)(2) be revised to describe each of the categories of services that make up the comprehensive and coordinated service delivery system, and congressional intent that each receive an appropriate share of III-B funding. This would clear up the ambiguity in the current language as to congressional intent for continuing support for community preventive services.

We endorse the recommendation of the National Governors Association for a wellness initiative. They recommended funding under title VII, but it could be done under title III or VII.

We support the proposed part D for title III contained in your bill, Mr. Chairman. We recommend that it be broadened beyond in-home services to adult day care and related services because they provide similar services in a lower cost congregate setting. Not either/or, but both.

We recommend that the subcommittee report instruct AOA to provide leadership toward implementation of section 306(A)(3), the designation of a community focal point for service delivery in each community, with special consideration to multipurpose senior centers. Without the establishment of a local partnership of the State and area agency in each community, the coordination of service to the older individual will remain a problem.

We recommend that adult day care be added to section 321, the list of optional services.

We recommend that advocacy for the elderly by service providers be protected from OMB Circular A-122 and IRS restrictions.

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We recommend that the role of the long-term care ombudsman be extended to in-home services and adult day care, and that the Administration on Aging be directed to fund demonstration projects to test the most effective ways to carry out this role.

In title IV we see a need for standards to be developed since the community service network is still maturing and evolving, and we recommend that the committee instruct AOA to support the development of standards for service, quality, and management of the network, and that they also be directed to fund demonstration projects and ways to increase minority participation in the title III programs.

In title V, as Mr. Hutton has said, the Community Service Employment Program continues to be successful. Every assessment has found it to be effective, efficient and socially productive. We believe that the program should remain as it is and be better funded, but the program is threatened by a provision inserted in 1984 which reduced the administrative allowance for operating the program from 15 percent to 13.5 percent on July 1, 1986, and will reduce it to 12 percent as of July 1987.

We eliminated staff positions, and the 61 local agencies who are subgrantees squeezed on their budgets to get down to that level. We have been told by many of these agencies that they will have to consider withdrawing from the program if the reduction to 12 percent takes place because they have no additional local funds to draw upon. The most likely to withdraw are small agencies in the less-populated areas. This would require us to consolidate projects for more economical operation so that we could monitor them with less staff. This would, in turn, displace older persons from the program. Meanwhile, the administrative allowance for the Job Training Partnership Act remains at 15 percent.

We recommend that the administrative cap be retained at 13.5 percent by deletion of the next scheduled cut, and that the waiver provision be retained.

We also oppose the proposal for the title V plan to be signed by the Governor for each State. NCOA has excellent working relationships with every State unit on aging and sees no need for additional procedures.

In title VI, clearly older Native Americans have special problems, and I think that one of those problems can be addressed by this committee by making it clear that an Indian who receives a service under title VI should not be precluded from receiving other services under title III. The title VI funding is so thin that to make that the sole provider, it seems to me, is extremely restrictive.

We also support a series of amendments which will be proposed by the National Indian Council on Aging.

On title VII, as I stated previously, the National Governors Association has recommended an initiative on the promotion of wellness as a parallel to their suggested initiative on in-home services. We agree that the congregate programs of health screening, health education and exercise can often prevent or delay physical impairment. Senior Centers are becoming increasingly active as wellness centers, and we recommend that the subcommittee report stress its strong support for funding these services under title III or title VII or both.

Thank you, Mr. Chairman.

[The prepared statement of Donald Reilly follows:]

THE NATIONAL COUNCIL ON THE AGING, INC.
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REAUTHORIZATION OF THE OLDER AMERICANS ACT

Testimony by

Donald F. Reilly
Senior Vice President
The National Council on the Aging, Inc.

Before

The Subcommittee on Human Resources
of the
House Education and Labor Committee

April 6, 1987

Chair Barbara Skler; 1st Vice Chair Frankie M. Freeman, Esq.
2nd Vice Chair James T. Sykes; Secretary Elva O. Walker; Assistant Secretary Sylvia Yuen, Ph.D.
Treasurer James Gunning; Assistant Treasurer James H. Agee
President Jack Ossofsky; Senior Vice President Donald F. Reilly

Mr. Chairman, the National Council on the Aging, Inc. is pleased to present our comments on, and recommendations for, the reauthorization of the Older Americans Act. My name is Donald F. Reilly. I am the NCOA Senior Vice President. Prior to joining NCOA in 1979, I was the Deputy Commissioner of the U. S. Administration on Aging for seven years. In that role, and in previous positions, I was involved in developing most of the provisions of the current Act, including the drafting of the sections which mandate the establishment of the area agencies on aging.

The National Council on the Aging includes as membership units, the National Institute of Senior Centers, National Institute on Adult Daycare, National Institute on Community-based Long-term Care, National Institute of Senior Housing, National Association of Older Worker Employment Services, National Voluntary Organizations for Independent Living for the Aging, and the National Center on Rural Aging. We represent a very broad coalition of organizations, agencies and individuals concerned about meeting the needs of older persons.

Overview -- Title III

The enactment of the Older Americans Act of 1965 was a timely response to the emerging needs of the first sizeable number of retired persons in our history and the growth in numbers of the older population. We knew little in 1965 about the life changes that accompany retirement from the work force. We knew less about the potential of this new group for volunteer service and community service employment. Social isolation was a newly discovered phenomenon. The frail elderly were not yet identified as a growing subgroup of the older population. But it was already clear that older persons, as a group, had significant needs for services and opportunities, and that this population and its needs, would continue to grow.

During the 22-year period since enactment, older persons have grown rapidly in total number. In 1965 there were 18.4 million persons over the age of 65, constituting 9.5% of the total population. The number increased to 28.6 million in 1985, 12% of the population. It is projected to rise to 39 million in the year 2010, 13.8%; and to 65 million in 2030, 21.2%, as the baby-boom generation becomes senior citizens. The age profile has also been changing as increasing numbers live into their 80's and 90's. The population age 80 and over was 1 million in 1965, 0.6% of the total population. It is projected to rise to 8.6 million, 2.5%, by 2030. This old-old group is more likely to have severe and multiple impairments, which put them at higher risk of needing in-home and community-based services and of having to enter a nursing home.

During this period, the Older Americans Act and the programs operated through its funding have continued to evolve. Originally, under Title III, state agencies on aging made seed money grants to senior centers and other community service agencies for the start-up and expansion of services. The Act was amended to have area agencies on aging designated by the state agencies. The role of each area agency is to provide leadership to all organizations which serve, or should serve, the needs of older persons, and to fund selected service providers toward development of a "comprehensive and coordinated service system to serve older individuals" within its multi-county, county or city planning and service area. The Act was subsequently further amended to have area agencies "designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multi-purpose senior centers as such focal point." Provisions for the development of long-term care ombudsmen and legal services were also added. The 1984 reauthorization added further area plan requirements: ". . . facilitate the coordination of community-based long-term care services designed to retain individuals in their homes . . . and designed to emphasize the development of client-centered case management as a component of such services; . . . work to ensure community awareness of and involvement in addressing the needs of residents of long-term care facilities; . . . and assess the unmet needs for services of abused, neglected and exploited older persons."

The periodic changes in Title III have responded to increasing information about the needs and problems of older persons identified by senior centers and other community-level Title III service providers, Title V Senior Community Service Employment programs, state and area advisory committees, public hearings on state and area plans, national aging organizations and Title IV research and demonstration projects. The consistent intent of these incremental amendments has been to increase the accessibility of services to older persons who need them, and to reduce fragmentation of services in order to assure that service delivery is coordinated to meet the specific needs of the individual older person.

A national network on aging has emerged to respond to this intent. It is made up of 57 state agencies on aging, 670 area agencies, over 10,000 senior centers, and approximately 8,500 other service provider agencies, augmented by approximately 87,000 volunteers, and national voluntary agencies. Its primary focus has been on preventing dependency by combatting social isolation and loneliness, providing social services, and providing opportunities for older persons to remain active in their communities. This focus is expanding to include services to the rapidly growing number of frail older persons in their communities. This change had begun prior to 1984, but the pace has been accelerated by the 1984 amendments, state concerns about rapidly rising Medicaid costs, which lead to state targeting initiatives by Title III, and a general lack of program funds to serve the seriously impaired who are not residents of nursing homes.

The service needs of severely impaired older persons frequently require a mix of health care and social services. These services are much more labor-intensive, which raises the cost, whether in group settings or in the home. When delivered in the home, the one-on-one nature of these services further raises the cost. As the network moves into this area in a period of rare funding increases, several serious issues arise that could change the basic nature of the Older Americans Act in undesirable directions.

The first problem that the increasing number of impaired older persons in our communities, their families, and the Title III network are confronted by is the lack of a national policy on long-term care. By default, Medicaid has become the major funder of institutional long-term care. It was not designed for that role. Neither Medicare nor Medicaid is designed to be a major funder of community long-term care, whether in-home or community-based congregate services. Thus, other than out-of-pocket costs by impaired older persons or their families, the services are paid for by an unstable combination of Medicaid, Medicaid waivers in states which have such waivers, the Title XX Social Services Block Grant, Title III of the Older Americans Act, and state and local funds. The combination varies from state to state, and community to community.

The need for in-home and community-based long-term care services is growing rapidly. The natural growth resulting from the increased numbers of the old-old is being accelerated by the "sicker-and-quicker" hospital discharges resulting from the Medicare prospective payment system. As the states search for more money to meet these needs, the Older Americans Act Title III-B funds are a tempting target because they are flexible and have low state and local matching requirements. These pressures have resulted in an increasing number of state and local targeting initiatives which tend to restrict Title III-B services to the frail elderly. Some proposed amendments to the Act would move in the same direction. We disagree with this movement because it will incrementally turn Title III-B into a health-care oriented community long-term care adjunct to Medicare and Medicaid, with funding completely inadequate to the role.

We believe that the answer to the need for a health-oriented community long-term care system is to be found in proposals such as H.R. 65, introduced by Congressman Pepper. It would create a Medicare Part C, funded by a tax, to pay for these necessary services. This approach would provide a guaranteed funding base, make community long-term care an entitlement for those who need it, and avoid means testing. If legislation of this type cannot be enacted this year, then we favor interim measures to generate substantial additional funds, such as liberalizing the current Medicare home health regulations and policies, and making the Medicaid Section 2176 waiver provisions available to all states.

The Title III program has made a substantial investment in the development of service delivery systems providing congregate preventive and supportive services in communities across the nation. Information and referral, counseling, health screening and education, legal and financial counseling, home repair, special transportation, congregate meals, group activities, support groups, and volunteer projects can help maintain independence and prevent or delay a future need by many older persons for in-home services, adult daycare, or institutional long-term care. Senior centers and other agencies providing these services should remain an integral part of the Title III continuum of services, or we will weaken the service continuum at one end while attempting to strengthen it at the other end. We also oppose any increase in the age range covered by the Older Americans Act, since it would be another move to reduce preventive services.

It is in the area of in-home services and congregate programs for the frail where social services and health services come together in blends which are still evolving. Adult daycare is a rapidly increasing service which provides social daycare for impaired older persons. Some agencies have specialized in providing daycare for older persons whose impairments require periodic health or health-related services. This type of service is usually called Day Health Care. Public policy has not yet clearly addressed the appropriate funding sources for each type, and the line of demarcation between them.

Some older persons confined to their homes can be maintained by home-delivered meals, friendly visiting, telephone reassurance, and chore services. Some also need homemaker services. Others also need home health aide services. Others need more intensive medical services. How Medicare, Medicaid, and Title III funding should come together in this area has also not been resolved.

The National Association of Area Agencies on Aging reports that their member agencies are already spending a disproportionate percentage of their funds on services for the frail home-bound person. We believe that this reauthorization of the Act should make it clear that Title III funding for in-home and adult daycare should be limited to those services currently non-reimbursable through Medicare, i.e., long-term assistance with personal care, homemaking, shopping; that a balance should be maintained between preventive and maintenance services; and that a new funding source is needed for medically-oriented community long-term care.

Another issue is related. The flat funding in recent years, while the size of the older population has been growing and the number of severely impaired persons in the communities has been increasing, has generated proposals for authority to impose mandatory sliding-scale fees for service. The philosophy of the Older Americans Act from the beginning has been that no means test would be imposed, though voluntary contributions could be sought. This important principle should be retained. The introduction of complex bureaucratic rules and procedures to set fees by income level would be a major step into means testing, and a diversion of limited service dollars to administering these tests.

A third issue is that the general cutbacks and capping of domestic programs have caused some groups who advocate for special populations to consider seeking special funding set-asides within the Older Americans Act. The system-building role of state and area agencies includes reaching out horizontally to other service systems, such as mental health, developmental disability, and the blind.

It also includes assuring that the needs of all older persons are considered in the development of area service plans. However, the Title III-B funding is too limited to make special set-asides a feasible pattern. This does not conform to the principle of local funding flexibility.

Overview -- Title V

The Senior Community Service Employment Program continues to be successful. NCOA is one of the national contractors who work with the Department of Labor to find low-income older persons who want to return to the work force, and place them in subsidized community service employment or unsubsidized employment. We operate through local agencies in 61 communities across the country, and directly operate a large Los Angeles project.

NCOA Title V operations provided employment opportunities for 9,762 older men and women during the last year. Unsubsidized employment placement was achieved for 1,513 participants, and subsidized community service employment was located for 8,249 low-income older workers. The work they do allows community service agencies to expand their services to persons who need them.

More than 80% of the participants were above 60 years of age. 84% had income below the poverty level. Almost 75% were older women. 44% had less than 12 years of education. 39.1% were minorities.

This program is threatened by a provision inserted in 1984, which reduced the administrative allowance for operating the program from 15% to 13-1/2%, on July 1, 1986, and which will reduce it to 12% as of July 1, 1987.

The reduction to 13-1/2% from 15% was a 10% cut. We eliminated staff positions, and the 61 local agencies who are our subgrantees squeezed on all components of their budgets. We have been told by many of these agencies that they will have to consider withdrawing from the program if the reduction to 12% takes place, because they have no additional local funds to draw upon. The most likely to withdraw are small agencies in the less populated areas. This would require us to consolidate projects for more economical operation, so that we could monitor them with less staff. This, in turn, would displace older persons from the program.

Meanwhile, the administrative allowance cap for the Job Training Partnership Act, the Department of Labor's largest employment program, remains at 15%. There is no logical basis for the lower rate for Title V.

The further reduction to 12% for Title V will be counterproductive as to program quality and effectiveness. We urge the Subcommittee to delete the provision for the further reduction, and to restore the cap to 15%, comparable to JTPA.

Another issue in SCSEP is the per-enrollee unit cost. The current level was set at $5,111 in 1981. It has not been adjusted since, dispite inflation and rising costs in areas such as Workers' Compensation, Social Security, and other administrative costs. We recommend that the per-enrollee unit cost upon which slot allocations are made be increased by the 1981-86 inflation increase.

Overview -- Title VI

It is clear that older Native Americans have special problems. The establishment of Title VI was a step forward, since it explicitly provided for grants for Indian Tribes. However, the proportion of minority persons served under Title III has declined. There are older Indians living in communities across the country who are not reached by the Tribes, or by area agencies under Title III. The low funding level of Title VI has limited the scope of services by the Tribes. Therefore, there is a need for a crossover provision. The Subcommittee should make clear that Indians who receive a service under Title VI should not be precluded from receiving other services under Title III. We also support a series of amendments which will be proposed by the National Indian Council on Aging.

OTHER RECOMMENDATIONS

Reauthorization Period

The programs under the act should be extended four years, through fiscal year 1991, as contained in your bill, Mr. Chairman. A longer period than the usual three extension will help assure stability and a focus on mid-term as well as short-term planning.

Appropriation Authorizations

The authorization of appropriations for fiscal year 1988 and subsequent years should be for specific amounts which reflect the continued rapid growth of the older population, and the fact that there is not one community in the nation that has a truly comprehensive and coordinated service system for older individuals. "Such sums" authorizations, as recommended by the Administration, are an invitation to appropriations reductions in this period of competition for resources. The Older Americans Act programs are not "mature" in the sense of having substantially achieved the legislative program goals. These programs are still evolving, and serving only a portion of the population which needs the services. We recommend at least a 20% increase for Titles III-B, III-C1 and III-C2, and Titles V and VI.

We also oppose including the Older Americans Act appropriations into a generic Office of Human Development appropriation, as proposed by the Administration.

RECOMMENDATIONS FOR TITLE III

Categories of Services

Section 306 sets forth the requirements for area plans. 306 (a) (1) states that each area plan shall "provide through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance or construction of multipurpose senior centers . . . ."

306 (a) (2) requires that each area plan shall "provide assurances that an adequate portion of the amount allocated for part B to the planning and service area will be expended for the delivery of each of the following categories of services:

(A) . . . access . . .;

(B) in home services . . .; and

(C) legal assistance . . . ."

The three categories of service were originally listed for this protection because of a concern that they were underfunded, since the great majority of funds were being committed to other community services. Many now interpret this provision as stating a priority for the three listed areas of service over other community services. This misconception should be rectified.

306 (a) (2) should be revised to become a logical corollary to 306 (a) (1). We recommend the following language:

(2) "provide that an appropriate proportion of the amount allotted for Part B to the planning and service area will be expended for each of the categories of services which constitute a comprehensive system:

(A) . . . access . . .;

(B) community services provided outside the home (whether individually or in group settings);

(C) in home services . . .;

(D) services provided to the institutionalized; and

(E) legal assistance . . . and advocacy."

This structure would eliminate the ambiguity inherent in the current provision by changing it into a description of the categories which make up a comprehensive system, which is not defined elsewhere in the act. It would make clear that the Congress does not down-rate the importance of preventive and supportive services delivered outside the home by multipurpose senior centers, daycare centers and other service providers. It would make clear that some outreach to the institutionalized elderly is an appropriate part of each community services plan. And it would make clear that the allocation of funds between these catgories would be done by the area agencies on the basis of local circumstances.

Program Coordination

Section 306 (a) (3) provides that area agency plans shall "designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers as such focal point." Some states and area agencies have implemented this provision, but most have not. Even where designations have been made, in most cases there has been little or no increase in resources awarded or authority conferred to implement the focal point functions. There has been no leadership by the Administration on Aging in this area.

A community focal point for service delivery should be the local partner of the area agency and state agency in each community. It should be a highly visible one-stop location for older persons and their families to get information on the services and opportunities available, provision of needed services on-site wherever feasible, referral to other appropriate service providers, and, coordination of services as necessary. This is not a feasible role for an area agency because their jurisdiction covers a multi-county, county or city area.

Without such designated community focal points, the further development of coordinated service delivery will be severely hampered. Even today in most communities, an older person or family member seeking assistance that involves multiple services is likely to run into major difficulties in identifying what services are available, who provides them, feasible alternatives, and how to integrate them into a supportive package. Access to needed services, and coordinated delivery tailored to individual needs are the functions that are central to the role of community focal points. The Subcommittee should make clear in its report that it expects AoA to exert leadership in achieving compliance with the full intent of the focal point provision.

Adult Day Care

Adult Day Care is a newly emerging service. It meets a critical need of working families for care of an impaired elderly parent or relative during the work week. This has become much more important with the large-scale movement of women into the work force. It also provides temporary respite for full-time caregivers. It is growing because the need is urgent, but the growth is restricted by lack of funding. This limits the access of lower and middle income families to an additional social support which may avert the need for more expensive in-home care or entrance into a nursing home.

Adult Day Care should be added to Section 321 (a), the list of optional services which can be supported under Title III, Part B, "Supportive Services and Senior Centers." It should be inserted as item (6), with the current items (6) through (19) being renumbered.

Also, we recommend that Section 307 (b) (13) be amended to make it clear that older persons and handicapped or disabled individuals who have not attained age 60, but who attend an adult daycare center, are eligible for participation in the congregate meals program at the day care site.

Senior Center Operation Costs

The use of Title III, Part B, funds for the purpose of assisting in the operation of multipurpose senior centers is authorized in 321 (b) (2). This location causes confusion because 321 (b) (1) deals with the acquisition, alteration, or renovation of existing facilities and the construction of new senior centers. We recommend that the present 321 (b) (2) be relocated as the last item in 321 (a), the list of eligible activities under "Supportive Services and Senior Centers."

Long-Term Care Ombudsmen

Section 207(a) (12) should be amended to extend the responsibility of long-term care ombudsmen to include in-home and community-based long-term care services as well as institutional facilities. The possibilities for abuse appear to be greater in the one-on-one home-care situation than in the supervised setting of a nursing home. Additional funds will be needed to carry out this important but difficult task, and we recommend that the Committee Report direct the Administration on Aging to fund demonstration projects to determine the most feasible techniques for carrying out this role.

New Title III, Part D

We recommend that the new Title III, Part D, included in H.R. 1451 be modified to include Adult Daycare, which provides similar supportive services in a congregate setting. This new part will be valuable because it provides a focus within Title III on the need for social care for frail older persons, and provides additional funds for the purpose.

RECOMMENDATIONS FOR TITLE IV

Program Standards

NCOA has recently developed, through our National Institute on Adult Daycare, the first national standards for development and operation of adult daycare centers. We previously developed, through our National Institute of Senior Centers, national standards for the development and operation of multipurpose senior centers. We are currently developing, through our National Institute on Community-based Long-term Care, national standards for case management.

The delivery of needed services is critically important. But it is equally important that the services be of high quality, and effectively delivered and managed. The introduction of standards for service delivery becomes increasingly important as the clientele becomes older and more frail. The NCOA Institutes are developing standards through committees of volunteers from community agencies, supported by our limited resources. The work on development and updating would be speeded up greatly by additional funding for the gathering of survey data and the support of committee workshops.

We recommend that the following language be added to Section 421 (c) (2): ". . . and develop standards to assure high quality services and effective delivery and management of such services."

We also recommend that the committee report direct AoA to provide support for the development and dissemination of standards, leadership to the states toward adoption of national program standards, and support for technical assistance in implementation.

Minority Participation

We recommend that the Committee Report direct that AoA seek proposals for an analysis of the current reporting systems and demonstration projects on how to increase minority participation in Title III service programs.

RECOMMENDATIONS ON TITLE V

Administrative Cost Limitation

The current provision which will reduce the administrative cost limit from 13-1/2% to 12% should be deleted. The reduction last year from 15% to 13-1/2% has already caused operational problems. A further reduction will cause some local community agencies to drop out of the program, forcing the movement of slots to consolidated projects in other communities. It will also require reductions in technical assistance, training and monitoring. The impact of the further reduction will be counterproductive to the job placement program.

Enrollee Unit Cost

The enrollee unit cost should be increased to compensate for inflation.

Governor's Signature on Plan

We oppose the proposed amendment which would require each Governor to sign a plan for equitable distribution of program slots within the state, including the slots of all national contractors, prior to the release of Title V funds each year. NCOA works closely with each state agency to jointly work toward further equitable geographic distribution within each state. We are aware of no problems with our relationships with any state. The proposed procedure appears to merely add another procedural layer to the program.

RECOMMENDATIONS FOR TITLE VI

The need for services for older native Americans is very large because of the prevalence of deep poverty. Further, the delivery of services to this population is especially difficult due to the geographic isolation of reservation homes. We recommend a 20% increase in the funding of Title VI to help address these problems. We also endorse the recommendations of amendments that will be made by the National Indian Council on Aging.

RECOMMENDATIONS FOR TITLE VII

The National Governors' Association has recommended an initiative on the promotion of wellness as a parallel to the initiative on in-home services. We agree that congregate programs of health screening, health education, and exercise can often prevent or delay physical impairment. Senior centers are becoming increasingly active as wellness centers. We recommend that the Subcommittee Report stress its strong support for funding of these services under Title III and Title VII.

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Thank you again for the opportunity to present our views. NCOA will be pleased to answer any questions about our comments or recommendations. We will also be pleased to work with the Subcommittee in any way that would be useful.

Mr. KILDEE. Thank you very much, Mr. Reilly.

Mr. Simmons?

STATEMENT OF SAMUEL J. SIMMONS, PRESIDENT, NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

Mr. SIMMONS. Thank you very much, Mr. Chairman.

Mr. Chairman, NCBA considers equitable treatment for minorities to be the single most important issue for the reauthorization of the Older Americans Act. This becomes even more critical now because the minority participation rate in title III-B supportive services and Senior Centers program has declined by 24.7 percent during this decade, from a high of 21.9 percent in fiscal year 1980 to a low of 16.5 percent in fiscal year 1985. The harsh reality is that the minority participation rate has dropped every year during this decade except for fiscal year 1982, when it remained unchanged.

A similar pattern exists for the title III-C nutrition program for the elderly. The minority participation rate has declined every year since 1980 except 1983. Overall, the minority participation rate has dipped by 13.7 percent from 19.0 percent in fiscal year 1980 to 16.4 percent in 1985.

Aged blacks have been negatively affected. In fact, nearly 300,000 fewer blacks received title III-B supportive services in 1985 than in 1980. The aged black participation rate has plummeted by 23.0 percent during this period, from 13.9 percent in 1980 to 10.7 percent in 1985.

The aged black participation rate for the elderly nutrition program has declined by 9.8 percent during this decade, from 11.2 percent in 1980 to 10.1 percent in 1985.

As a practical matter, the 1985 participation rate for all major elderly racial and ethnic minority groups is at an all-time low for the 1980's.

I don't want to continue to overwhelm you with statistics, but there have been a number of other equity studies which have further confirmed what I have said to you.

We have several recommended measures to help reverse the downward slide for the elderly minority participation in the Older Americans Act program. The 1984 Older Americans Act amendments emphasized that low-income aged minorities were a priority for receiving services. This provision helped to clarify that older minorities were a likely target group for receiving title III services; however, a clear-cut need exists to strengthen this language to emphasize that low-income minorities should be served on the basis of their need for services. Equity studies show that minorities are two and a half to three times as great in need of services as other groups.

We favor a variety of things to really deal with this, and one of the things I was thinking about while I was sitting here, I was saying that each year I come up before another committee and I say these same things over and over again. I start off citing statistics and the need, and nothing happens. And you know, firmly, I don't think that anything will ever happen until we are more specific and explicit in terms of the language that's set forth; until there is a greater commitment on the part of whatever administration is in power to do something about it. If they are really serious—if we are really serious about doing something about this, you're going to have to put the right kind of program guidelines, the right kind of regulations; you're going to have to collect the right kind of data; you're going to have to train staff more than we have in the past. And I think that each year we come back again and we put language in there, and not very much happens because we have not developed the institutional mechanisms to increase minority participation. Either we're serious about it or we're not.

Now, in terms of title IV, we have a couple of recommendations relating to title IV, the Training, Research and Demonstration Program. First, we urge the Human Resources Subcommittee to support the existing priority for funding demonstration projects responding to the needs of the low-income minorities and limited English-speaking individuals. This provision can be an effective tool if appropriately funded to develop demonstrations which can be retrofitted nationwide for improving the delivery of services to older minorities. We urge the Human Resources Subcommittee to work with the Appropriations Committee to assure that this provision is adequately funded.

Secondly, NCBA recommends that the 1987 Older Americans Act amendments should promote career preparation and training for minorities, especially at historical black colleges. This is needed to emphasize that career-level education for minority group individuals is a high priority goal. It is essential to attract more minorities into the field of aging.

I would share with you my views on title V, but I would be underscoring what three other persons have said. The only point that I want to make in that regard is how devastating I think it would be if the administrative cost limits are cut back as is now being proposed. It would be very devastating on some of the smaller States, and especially the smaller national contractors because they don't have the advantages of economy of scale. And I would hope that we would not leave the setting of the administrative cost limits up to the Administration, to say that we would do this on a case-by-case basis. I think that if it's in the statute, then we are in a position to predict what it's going to be and we can plan for it. But there is no question but that none of us can live with cutting back to 12 percent as is being proposed.

So we would hope that your committee, in terms of its recommendation, would recommend that that traditional language be put back and that the administrative cost limit go back to what it originally was because it's comparable to what it is today in JTPA, and we think that the same thing should be true in terms of title V.

I appreciate this opportunity to appear before you, and I'm just sorry I was the last one on.

[The prepared statement of Samuel Simmons follows:]

TESTIMONY BY

SAMUEL J. SIMMONS
PRESIDENT
NATIONAL CAUCUS AND CENTER ON BLACK AGED, INC.

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES
HOUSE COMMITTEE ON EDUCATION AND LABOR

ON

REAUTHORIZATION OF THE OLDER AMERICANS ACT

APRIL 6, 1987

Mr. Chairman and Members of the Human Resources Subcommittee the National Caucus and Center on Black Aged welcomes the opportunity to testify on the reauthorization of the Older Americans Act. As you have requested, we shall keep our remarks brief. Our statement will focus largely on improving minority participation in Older Americans Act programs.

A. Serving Aged Minorities More Equitably

NCBA considers equitable treatment for minorities to be the single most important issue for the reauthorization of the Older Americans Act. This becomes even more critical now because the minority participation rate in the Title III-B supportive services and senior centers program has declined by 24.7 percent during this decade, from a high of 21.9 percent in fiscal year 1980 to a low of 16.5 percent in 1985. The harsh reality is that the minority participation rate has dropped every year during this decade except for FY 1982, when it remained unchanged.

A similar pattern exists for the Title III-C nutrition program for the elderly. The minority participation rate has declined every year since 1980, except for 1983. Overall, the minority participation rate has dipped by 13.7 percent, from 19.0 percent in FY 1980 to 16.4 percent in 1985.

Aged Blacks have been negatively affected. In fact, nearly 300,000 fewer Blacks received Title III-B supportive services in 1985 than in 1980. The aged Black participation rate has plummeted by 23.0 percent during this period, from 13.9 percent in 1980 to 10.7 percent in 1985.

The aged Black participation rate for the elderly nutrition program has declined by 9.8 percent during this decade, from 11.2 percent in 1980 to 10.1 percent in 1985. As a practical matter, the 1985 participation rates for all major elderly racial and ethnic minority groups are at an all time low for the 1980's.

I do not want to overwhelm you with a long litany of statistics. Our point is short and simple: A serious problem exists in serving older minorities more equitably under the Older Americans Act. Unfortunately, this dilemma is worsening, rather than improving. Virtually every major relevant study has concluded that minorities are underserved, including the 1982 Civil Rights Commission report, earlier equity studies, and other objective analyses of the issue.

B. Title III Recommendations

Several measures are needed to help reverse the downward slide for the elderly minority participation in Older Americans Act programs. The 1984 Older Americans Act Amendments emphasized that low-income aged minorities were a priority group for receiving services.

This provision helped to clarify that older minorities were a likely target group for receiving Title III services. However, a clear-cut need exists to strengthen this language to emphasize that low-income older minorities should be served on the basis of their need for services. Equity studies show that the minority aged's need for services is normally about 2 to 3½ times as great as for the non-minority elderly. NCBA strongly believes that the proposed statutory language can be a positive force in improving minority participation in Older Americans Act programs if this measure is appropriately monitored and implemented.

NCBA also favors new statutory language to promote the appointment of minorities on advisory committees and boards for area agencies on aging and state offices on aging. These advisory units can be influential in determining what types of services are provided and where they are delivered within the community. These decisions are often critical in deciding who is served under the Older Americans Act and how well they are served.

Mr. Chairman, NCBA further urges this Subcommittee to call upon the Administration on Aging to improve reporting requirements for minority participation in Older Americans Act programs. Moreover, AoA should issue regulations, program instructions, and other relevant information for regional AoA offices, state offices on aging, and area agencies on aging. Without these bare essentials, there will be no effective direction for improving minority participation in Older Americans Act programs.

C. Opposition to Provisions Impeding Participation by Minority Elderly

NCBA is also deeply concerned about a number of proposals to target more scarce resources under the Older Americans Act to the vulnerable elderly. NCBA certainly does not oppose serving vulnerable older Americans.

However, these recommendations typically involve health related services, which, in the judgment of NCBA, are more appropriately provided through other legislation, rather than the Older Americans Act. Moreover, these services for the vulnerable elderly will probably cost more and dilute existing limited resources for current client groups under the Older Americans Act. This does not make sense, in our opinion, especially since the minority participation rate for Title III supportive and nutrition services has already fallen sharply. In addition, low-income aged minorities have the greatest need for these services.

For these reasons, NCBA opposes measures to:

- Change the formula for allocating Title III funds on the basis of the population 70 or older, rather than 60-plus as under current law.
- Amend the definition of "greatest social need" to include vulnerable older individuals.
- Promote the establishment of community-based services if the emphasis is on providing expensive health-related services.

D. Title IV Recommendations

NCBA has two major recommendations for the Title IV training, research, and demonstration program. First, we urge the Human Resources Subcommittee to support the existing priority for funding demonstration projects responding to the needs of low-income, minority and limited English-speaking individuals. This provision can be an effective tool, if appropriately funded, to develop demonstrations which can be replicated nationwide for improving the delivery of services to older minorities. We urge the Human Resources Subcommittee to work with the Appropriations Committee to insure that this provision is adequately funded.

Second, NCBA recommends that the 1987 Older Americans Act Amendments should promote career preparation training for minorities, especially at historical Black colleges and universities. This is needed to emphasize that career level education for minority group individuals is a high priority goal. It is also essential to attract more minorities into the field of aging.

E. Title V Recommendations

NCBA is also calling for three major changes to benefit older minorities under the Title V Senior Community Service Employment Program (SCSEP). First, we urge that the program be continued and the authorized funding level be increased to permit more aged minorities and other low-income older Americans to participate.

Second, we recommend that the current $5,111 average cost per enrollee be adjusted for the following reasons:

1. The current average cost has remained in effect for six years, although Title V operating costs have risen in recent years.
2. The Social Security payroll tax has increased, and will continue to rise during this decade.
3. Title V program administrators have been given new responsibilities by the Department of Labor -- most

notably in the areas of equitable distribution and higher goals for unsubsidized placements.

Moreover, it is quite likely that the minimum wage will rise in the near future.

Third, NCBA supports a 15-percent administrative cap, the same limit that exists for most employment and training programs. The present two-step reduction -- from 15 percent to 13.5 percent in fiscal year 1986 and then to 12 percent in 1987 -- will adversely affect Title V operations, particularly for older Americans and the communities they serve. It will also be detrimental to national minority sponsors because they do not have the economies of scale that the larger sponsors have.

Some Title V participants will inevitably lose their jobs because of the lower cap. As a practical matter, sponsors will be forced to consolidate their operations by closing down smaller projects to lower their administrative costs. Unfortunately, this development may be especially harmful for the rural elderly. The bottom line is that the program may develop an urban bias, although poverty is generally more heavily concentrated in rural areas than in the suburbs or urban areas.

F. Conclusion

In conclusion, NCBA wishes to express its sincere appreciation to the Human Resources Subcommittee for this opportunity to testify today. We reaffirm our support for the Older Americans Act. We believe that this historic legislation has benefited senior citizens, local communities, and our nation.

We, therefore, urge that the Older Americans Act be extended for at least three years with increased authorized funding levels. We further urge that our proposals to make the legislation more responsive to older minorities be adopted when the Congress considers the 1987 Older Americans Act Amendments.

These measures are much needed. They are realistic. And, they will help to improve the Older Americans Act for the elderly of today and tomorrow, as well as our nation.

Mr. Chairman, I also ask unanimous consent to insert in the hearing record NCBA's comprehensive statement on the reauthorization of the Older Americans Act. This longer statement provides more detailed information concerning NCBA's position on a wide range of issues relating to the extension of the Older Americans Act.

Thank you for your courtesy. I shall be glad to respond to any questions that you may have.

Mr. KILDEE. Thank you very much, Mr. Simmons.

Let me ask you all this general question. Should this committee resist efforts to make the Older Americans Act more medically oriented? And if so, to what extent? We are getting pressured to put this disease in or this problem in. Could you comment on to what degree should we, perhaps, resist efforts to make OAA more medically oriented?

Mr. REILLY. Well, I might begin because I addressed it in my statement. I'd just like to pick up from that.

As we see it, it's an exceedingly difficult problem because there are increasing numbers of frail elderly; that's clear. At the same time, there are increasing numbers of people in the community who we think, with appropriate preventive services, can be prevented from becoming frail, or at least delayed from becoming frail. And the genius, it seemed to us, of the original design of the Older Americans Act was for a continuum of services, and we see it as being potentially pulled from this spectrum of prevention and support services into a medical orientation because of the very severe limitations on Medicare and Medicaid for funding services that are indeed medical.

We think that if the whole of title III, including nutrition funds, were put into one package to support services for the completely impaired, the frail elderly who need total care but are a bit short of needing nursing home institutionalization, it clearly would not pay for it.

So to distort title III-B by pulling it over to try to fill this enormous gap, which is a major problem in public policy but not the jurisdiction of this committee, would be a mistake. So that's why we recommended that the solution to this really ought to be addressed by a specific mechanism, preferably part of Medicare.

Mr. KILDEE. Anyone else care to comment on that?

Mr. LEHRMANN. I'd just comment that we would look at it in the same way in the sense that here we have a complete package dealing with the concerns of older persons in America; and to skew it in the direction where everything goes toward health, with limited amounts going toward the other objectives, I think would be moving in the wrong direction. We would support some other effort, either through Medicare or Medicaid, that would deal with this issue.

Mr. SIMMONS. We feel likewise. In terms of title III right now, many individuals are not getting the services that they should in terms of those existing programs there. And to load additional activities in there I think will only serve to further defuse the limited resources that are available.

On the other hand, we strongly feel that this issue ought to be addressed but not as a part of title III.

Mr. HUTTON. I concur with all of my colleagues on that one. There are some things that the Older Americans Act shouldn't do at all. I think it's a great danger for us to try to get into that medical field with our services. Otherwise, as I say, you're further complicating a bad situation.

Mr. KILDEE. I think we can distinguish between health and medical, can we not? For example, the nutritious meal——

Mr. HUTTON. Sure.

Mr. Kildee [continuing]. Will maintain that person's health, making it less necessary for that person to require medical attention.

What I have found in visiting homes of elderly people in my district is that quite often a person is elderly and frail, so he or she, quite often it's a "she," will not prepare a proper, nutritious meal, and therefore their health declines more. So perhaps we can distinguish between health and medical; medical is coming in after the fact that the health has failed.

Mr. Hutton. Well, there are, I know, people still urging home health aides to do work which they shouldn't do. I'm speaking against that. I think we really need the care which you suggested in your bill. I think it's important to help frail older people to lead a happy life by being able to move around and doing their chores.

Mr. Kildee. One of the reasons I put the frail elderly section in is that you can respect people's dignity much more if you can help them to remain in their homes. I think it's both morally right to do that, and fiscally sound, too. Give them some minimal services: bring them meals first of all; call upon them; give them some assistance, not medical assistance, but some assistance in their home—even calling upon them, making sure that they are OK. That type of assistance.

Mr. Hutton. Keep them out of institutions which cost so much.

Mr. Kildee. Much more.

So I think it's morally right. It's not a medical service we're giving there; it's a service to keep them functioning so they can remain in their homes.

Mr. Reilly. I would say it's everything you just said, and it responds to the desires of older people themselves. I'm on the Board of Directors of a senior center in Northwest Washington, and I see the people that the staff works with. Clearly, the continuing major fear that those people have is that they're going to become impaired to the point where they will have to go into a nursing home. Anything that that senior center can do in terms of packaging services together at the center, as long as they're mobile enough to get to the center—at the home, if they can't get out of the home—is just received with extreme gratitude because what they see on the other side of that divide is a nursing home. And even where the nursing home is an attractive facility and is well-run, it is a rare older person who wants to enter that. They really want to remain in their own homes, and that's the strength of title III as I see it.

Mr. Kildee. My mother is 87 years old, and 2 years ago she fell and broke her pelvis. Under the DRG's, she was scooted out of the hospital pretty fast and into a nursing home. Her determination was to get out of there, and she's back in her home now. She gets Meals on Wheels, someone comes in and helps her bathe, and she's independent. And she is so happy to be there in her own home, the home she's lived in for over 50 years.

That is respecting people's dignity. And fiscally it's very sound, too.

Mr. Reilly. Just a small illustration of how widespread this need is becoming, we just had an annual conference of the National Council on the Aging in Chicago and three of us went and appeared on a local television program there to talk about community long-term care. At the end of the half-hour program as we're getting down, taking off the microphones and what have you, first of all, one of the cameramen came up and asked a question about his mother who was frail, and wanted advice on how to get adult day care. And while that conversation was going on, two other people came up and joined in with similar types of problems. And I counted—there were only 12 people in that studio, crew members and what have you, and there were three out of the 12 that came up that had some situation; a father in one case, a mother in another, and a grandmother in another case, and all of them with real painful problems in terms of how to meet this need and keep the person out of the nursing home.

Mr. KILDEE. Twenty-five percent of the people there?

Mr. REILLY. That's correct.

There's beginning to be a dawning of the extent of this problem on the part of some corporations. There's a survey—I think it was Traveller's that did it—that discovered a significant proportion of their working population had day care problems that were not child care problems but were adult care problems with their parents or grandparents.

Mr. KILDEE. The reason I asked the question is because the Older Americans Act has such a good track record, that there is pressure to include various programs in it that more properly belong in Medicare, Medicaid, or catastrophic illness. With the limited amount of dollars that we have for this program, I'm afraid we'll pull money away from the social aspect and the nutrition aspect—which is health, but not medical. Nutrition is preventive, and that's the concern. But the pressure tends to be put on the Older Americans Act to take care of some of these things where there are deficiencies, perhaps, in other programs. I appreciate your response.

Mr. Tauke?

Mr. TAUKE. Thank you, Mr. Chairman, and I too appreciated the conversation you just had.

One of the things that is of concern to me is the outreach segment of the program and the concerns that we have about those who are not currently served by the program. We obviously have a special concern with the minority population, which I want to get to in a second. Why is it, first of all, that we have a significant number of people who apparently need the services but don't get them? And what can we do to get those services to people?

My own observation has been, in the case of some of my own relatives as they become older and probably need these services, they have a tendency to withdraw and to not want to participate in things. Is that the problem, or is there some other difficulty we have in getting services to people who need them?

Mr. REILLY. Well, I think that's certainly one major part of the problem. I think another part is that thing I referred to in my statement about the very limited implementation of the section that calls upon Area Agencies to designate in each community a community focal point for service delivery. Somebody a bit earlier—I think it was Mr. Grandy—used the term, a "one-stop center."

One of the problems with services for older people in the community is that they tend to be fragmented, and it's hard for the older persons themselves or even the active members of their families to find all of those services and package them together in a way that meets, in many cases, the several needs of an older person who has impairments. And I'm convinced that an Area Agency cannot, over a multicounty or a county area, be present in each part of that spreadout community to provide that kind of individual outreach and visible focal point for providing information. It seems to me that that has to be brought down further into the community, and I think the designation of those community focal points can be a major step toward it.

I know I heard the present Commissioner on Aging speak at our conference last year, and she was describing a problem she had in her own family. She said that if anybody in the country ought to be able to put together a package of services to meet her mother-in-law's problems, it ought to be her, and she ran into very considerable difficulties because of much of this problem. A variety of different agencies provide different services; they go under different names and do not necessarily identify clearly in the phone books what they provide. And so the information and referral part of it is a major part which needs continuing attention.

Mr. Hutton. I really believe that lack of information is probably the biggest reason given in referring to these things. I was very interested in Mr. Hammerschmidt's proposal this morning because I think that that is worth it. I think it would be a good thing to try to study.

We'd like to see the service providers, all of them, play a much greater role in disseminating information about other programs. I said that in my earlier testimony. For example, I know that in food stamps, SSI, they're not really doing outreach in their programs; in fact, I have a feeling that they're told not to because, you know, the funds will run out if we do that. They pay no attention to the need; if we're going to keep this little party going, let's not go and tell everybody about it.

But information is vital and necessary. It should get out, and we should find ways to do this. I am glad that Mr. Hammerschmidt brought forward a proposal, too, because I think we've got to get that information out. I believe also that people working in every other program should be encouraged; we should say to them, look, have you looked in your context? Have you tried to see whether or not there are people eligible for this or that? Other people don't understand what's available. Most people—I mean, they know in our case that everybody needs a job. They want to work and they have a yearning to show that they're not just sitting by doing nothing; they want to participate.

But in other things, they can get the real help which they need if someone would tell them about it, and I'm sorry that we're not getting those things out as well as we should.

Mr. Simmons. I think that there isn't any question that the aging networks should do a more effective job in terms of interpreting entitlements to churches, community groups and things of that sort, because individuals do belong to those groups and individuals in those other groups don't know what they're entitled to. So I think the aging network needs to do a more effective outreach job, interpretive job, communications job than they've done in the past.

Then there's another image thing that I think we really have to wrestle with. Very often I go and talk to low-income people, low-income minorities in talking to them about food stamps and low-income energy assistance and Medicaid, things of that sort. Right off the bat, many proud seniors say, "I don't want to take that. That's welfare." And I think one of the things that we have to do more effectively than we have been doing is educating seniors about what their entitlements are. Many of these programs that we're talking about are entitlements to any senior, and they don't have to feel badly about it. You can be surprised at how very many low-income seniors will not apply for or try to get a service because of the fact that they look upon it as a handout, and this is something they've never wanted during their lives.

So I think we have a problem there in terms of really interpreting to people what this is that's available for them.

Mr. **Tauke**. Do we have any information which indicates if we do a better job of serving the lower income elderly citizen or if we do a better job of serving the low-middle or the middle or the upper-middle? Do we know where the services are going among the senior citizens?

For example, when you speak of the problems of the minorities, which is obviously a vexing problem for you and for us, is that a function solely of the racial or ethnic background of the individual? Or is it that we are losing lower income citizens generally in these programs?

Mr. **Simmons**. I don't know what it is for the middle and upper, but there isn't any question in my mind that the people who are the most under-served are the minorities, rural people, people who live in isolated areas, people who are out of the mainstream. Those are the groups that are least likely to be served.

But who is most likely to be served, I don't know the answer to that.

Mr. **Reilly**. Well, I think the whole data reporting system is a problem in this area because most of the data requirements that the Administration on Aging has applied to the meals programs—and when you get to title III-B, the whole social service area, the requirements are minimal there, so it's very hard to get your hands on that kind of information.

But let me turn back, if I may, to another thought. When Bill mentioned Congressman Hammerschmidt's proposal and you were asking, how do you get to these people, our instinctive reaction is to get the network to do it better. And my comment was, push the network down further into the community to do it.

I was suddenly struck by the thought of how commercial companies reach the "hard to reach," and the thought occurred to me of all these ads on television by insurance companies pushing Medigap insurance. And from everything I understand about it, they're very effective and they're selling lots of it by television. If you're trying to reach people who are in rural areas or socially isolated in big cities, one of the few common denominators of those people is that they watch a lot of television. It just occurred to me that a possibility might be to put together some sort of advertising council campaign. They do this sort of thing for lots of worthy purposes, and that could be tied together at a national level—an 800 number, perhaps—and they can insert local numbers; the general message would be put forth, and then local phone numbers given for people to be contacted by it.

Mr. **Tauke**. Before my mother passed away she was an advocate for the elderly at an Area Agency on Aging in Iowa. Her frustration was that the senior citizen centers, the congregate meal sites and so on would become almost like senior citizens' clubs, and you either belonged or you didn't belong. There was the inside group and then there was everybody else. And she said, "It's so difficult. You find some people who need the services; you persuade them to come and participate, and then a few days later they don't come back." Is that a problem?

Mr. **Hutton**. It's contrary to the theory of them being like senior citizen clubs. They come back all the time.

Mr. **Tauke**. But it seems that there were some people who felt that they didn't quite belong. Do you think that's a problem?

Mr. **Reilly**. Well, if I could make just one quick comment on that, the National Institute of Senior Centers is part of the National Council on the Aging. And one of the reasons that standards were developed was to meet a variety of needs that had turned up over the years in senior centers, and that is indeed one of the issues. And the set of standards that we evolved has never been adopted by the Administration on Aging or pushed by them, but we push them out through our own internal networks, and it is that outreach should be a major criterion of proper administration and looking at the community that's in that geographic area and how to make comfortable each of the segments of that community.

But it varies from place to place. There are centers that you can walk into where you see remarkable diversity and harmony and intermingling, and you go into other places and it can look like a social club.

Mr. **Lehrmann**. There's no question that that can happen. However, the effort has to be made to develop programs that incorporate everyone.

But extending beyond that, how do we find these people out in the community and out in rural areas? We could talk about advertising, but very often it's a one-on-one kind of situation in my observation, and I'm in that category of being well into at least the early part of being an older person. You know, it's that contact; and we need to develop, first of all, some people that will be trained to do this, and then to expand that further by having volunteers making individual contacts where we can go out and tell the people about the programs that are available. I'm very concerned, coming from a very rural State—you're from Iowa and I'm from Wisconsin, and you know how rural we can get—there are people back in the hinterlands that are not called on by anyone. And I think if we developed such an expertise, we could get volunteers to explain to the people, "Here's what's available and here's how you go about doing it."

The image problem is a great one. People look on this—particularly rural people, be they minorities or otherwise—look on it as a welfare program. Somehow we have to disabuse them of that and get on with the job of having more participation in the program.

Mr. **Tauke**. Those of us who run for office are pretty good at finding people and informing them. We know how to set up the networks to do that. In my pre-Congress days, when SSI first came into place, I headed the SSI alert network in five counties; I'm sure some of you were involved in that, too. And that's what we did. We got the volunteers to go out on a person-to-person basis and talk to people.

Mr. **Lehrmann**. To me, that's the way to get at it.

Mr. **Hutton**. One final comment on that subject. I hesitated at the beginning because I didn't want to appear unkind, but there is, in my view, a great warmth in the senior citizen club where people go regularly; they learn from each other; they talk to each other, they help each other. And the people who are at the leadership end of those clubs—not necessarily paid people, but volunteers—they seem to know what to do and they certainly help and train in some kind of way, which enables them to be outgoing to the people who come along and provide, and hold their attention.

I've gone to some of these food centers where people are just going for a meal; they're rushed in there, a lot of them, and rushed out as quickly as possible. They're given nothing outside of that program. They're not made to feel needed or wanted, and their advice is not sought nor are they given information.

I'd like—if I ever have much time in my life coming on—I would like to really push the people who look after feeding cases like this, to start looking at the people as the most important thing and not the food, to get to know them and to tell them about life. You know, talk to them just like they were friends. They would soon get to know what's going on. You would find many more people applying for the other things. It is a pity.

Mr. **Kildee**. We need a welcome wagon committee in each of these places to welcome new people in.

Mr. **Hutton**. That's an idea.

Mr. **Kildee**. Mr. Sawyer?

Mr. **Sawyer**. Thank you, Mr. Chairman.

Let me follow up on that particular line of thought because it really goes to something that we've been talking about all day long, and that is the dilemma we face in an arena and in a time when we've got a limited amount of money. Do we seek to fulfill the limited roles that we've defined for ourselves, whether we're talking in terms of the programs as you have discussed very specifically, in limiting that program menu that we offer; or when we talk about numbers of people as we try to reach out and include as many people as we possibly can, at the risk of diminishing the quality of the program of itself. We've been struggling with that in several different ways all morning today. And even in your discussion we've come down and talked about the medical side, the importance of being limiting. Yet I hear you talking about the quality of programming as it exists and the importance of expanding the opportunity to take part in that.

Where do we resolve that dilemma? How do we deal with the notion that some of those very funding structures that we were talking about early this morning work at direct cross purposes with the kind of thing you're talking about right now? Maybe that's not a fair question to ask a panel of people, but it really seems to me that it's a thread that's gone through everything that we've talked about.

Mr. **Hutton**. I had a feeling that the whole question that was brought up by one of the witnesses—although rather genuine in trying to help people—was going to result in less meals. I just feel it in my blood that that's what's going to happen.

Mr. **Sawyer**. Could I take it, then, that you would then oppose that?

Mr. **Hutton**. I would.

Mr. **Lehrmann**. I think that anything that's going to diminish it, the minimal amount that's already being done, when we see all the host of problems that come about as a result of our not acting, it really is important that we understand what our goals are and we seek to get the resources to get the job done. I think it's a must, because if we don't we're creating a bigger pool of people in the future that we'll have to take care of in a much more expensive way. And I think that keeping this kind of attention that we have in the Older Americans Act would really be very valuable in terms of taking care of that large bulge that's coming on in the future. So I guess if we can expend dollars to help people stay well, that's an important investment. We're doing that through the things that we're talking about here in the Older Americans Act.

Mr. **Reilly**. I would just endorse both of those statements.

Mr. **Sawyer**. And you would take the risk, expand the reach and then take the risk that we will be able to find the resources to meet the demands?

Mr. **Reilly**. Yes.

Mr. **Simmons**. I don't know if I understand you correctly. You're not talking about adding additional jurisdiction; you're talking about just getting people to more fully participate in what services are available now?

Mr. **Sawyer**. That's right, and take the risks in the funding formulas necessary to bring that about, even if it means that we may fall short in the near future.

Mr. **Reilly**. That's correct.

Mr. **Hutton**. You would get a lot of gains that you didn't realize, too. I can tell you that I've seen older people take hold of a club, and just by their beautiful nature, by themselves in the way they talk to others, they can stimulate all of the people in that club not only to help each other, which they do well, but they go out to their neighbors and they say, "Do you know what it's like at our club?" And they'll bring them in. And they begin to help each other. They begin to have more friends. They will share the can of dog meat, if it's necessary.

But the real issue here is that they will try to help each other when they're together. And you don't if you keep pushing them today and telling them, well, we've only got so many meals we can afford to give you this year; that's it.

Mr. **Sawyer**. Thank you.

Thank you, Mr. Chairman.

Mr. **Kildee**. We were discussing whether they should reimburse on the basis of the current year or the previous year. I worry about using the previous year. When I was raised during the Depression we said, "Oh, my gosh, company's coming; what will we do? Put a little more water in the soup." We should welcome company in this environment, shouldn't we? Welcome new participants?

Mr. HUTTON. I would agree.

Mr. KILDEE. That's why I asked the director if we should have a certain percentage of last year plus a certain percentage for growth. I do worry about that. I know that it might make it easier for the providers to have the certitude, but the incentive for inviting more people in might be diminished by that. I am concerned about that.

Mr. REILLY. Well, I certainly don't speak for the meal providers but I would be very surprised if they're looking for a cap on that program. I think more knowledge about what's coming down the pike would be highly desireable for them, but from having previous association with that program when I was in the Administration on Aging, I know that one of the things that all of the meal providers think is a very good feature of this is that there's essentially a resource to be called on there; that as they outreach and bring in more older people, that there is more funding available from the Department of Agriculture.

Mr. KILDEE. Several of you represent title V contractors who have requested the waiver of the administrative cap. What is your view of the Department of Labor's position that the current waiver is adequate?

Mr. REILLY. Well, I would certainly prefer to have the certitude of the legislation which says that it cannot go to 12 than to rely upon the—I am sure—good-intentioned analysis of the Department of Labor. We have submitted a waiver request; we're one of the ones that has done so. We're using every dollar of that 13.5 percent right now, and our structure is such that we operate the program through local community agencies. We subcontract with them. We've been told by a number of those agencies that took a reduction last year that they cannot take a reduction this year, and that they will just have to drop out of the program if they have to reduce again on the administrative side. The ones who have told us that have tended to be located in more rural areas and smaller agencies. We think that's totally counterproductive; it goes in the wrong direction because what we would have to do, then, in response is close out those projects, expand the larger projects because it's more "efficient"—it would be more economical; I don't think it really would be more efficient because we'd be losing rural participation.

Mr. KILDEE. What would the effect be on minority contractors?

Mr. SIMMONS. It would be devastating because in our point of view, this year coming up, we think that our admin cap is really going to be about 14.8 percent. And what we may have to do is look hard at some of the rural projects that we have to try to consolidate them; and I think in some places, as a result of consolidation, people are going to——

Mr. KILDEE. Further isolate people?

Mr. SIMMONS. That's right. You're going to end up literally cutting them off. And we firmly believe that we cannot survive with it going back to 12 percent. From our point of view, we think that for title V it ought to be the same thing as JTPA in terms of the JTPA activities that we run, and that's essentially 15 percent. That's where it was before, and we say that that ought to be there. We would much rather be in a position to know what we're going to get than to sit down and guess what someone may or may not give us.

Mr. **Reilly**. I would make one other point about this; that is that these reductions came through in the last reauthorization with no real discussion about them. It was really just sort of whistled through into the legislation and, in our view, had very little rational analysis to support it; as Mr. Simmons points out, 15 percent was the figure for both this and the JTPA program, which have a number of common elements.

One other point is that in some views, perhaps, a reduction from 15 to 13.5 doesn't sound like a lot; it's 1.5 percent. But it actually is a 10-percent reduction in the administrative allowance.

Mr. **Kildee**. With another 1.5 percent coming up July 1.

Mr. **Reilly**. That's correct.

Mr. **Lehrmann**. It's a size question. If we want just larger groups to serve, we're going to eliminate the smaller groups and we're going to also do as was presented here, forget about the places that are hard to serve, the rural areas and the like. And consequently, it looks like we're going in the wrong direction, too far in the wrong direction.

Mr. **Kildee**. Very often it's a popular thing to say, "Let's cut administrative costs." We'd better analyze that carefully to see what we're actually doing.

Mr. **Hutton**. We're in a particular situation. First of all, I entirely agree that this is extremely hard on the minorities and it's very hard on the smaller groups that do not have the economies of scale which an organization has which has been in the thing longer and has more aides to operate, more job stops available. You can spread it out. And we've done that successfully over the 20 years that we've run this program in the National Council of Senior Citizens. We're not a monied operation at all. We're not a big, wealthy organization, yet we've been able always to keep below—even below the 12 percent, we would still be able to put our administrative costs less than that. What we have arranged with the Department is that whatever the percentage is—if it's 13.5 percent—if we can still do it less, we will utilize the extra funds in hiring more aides and giving more older people jobs.

So we want to save money where we can without destroying the program. I can assure you that we're running one of the finest programs in the country, but we want to make sure that all old people are able to function with that program as they see fit. Certainly, the minority people are going to be hurt, and smaller groups are going to be hurt, and it would make sense to at least utilize—for one, the JTPA programs with the States—if that gets 15 percent, it's clearly not satisfying if you reduce these programs down, first to 13.5 and then to 12.

I think that going to 12 is going too far, and I would support for the minority groups a full 15 percent.

Mr. **Kildee**. I want to thank the panelists.

Mr. Sawyer, do you have any additional comments or questions?

Mr. **Sawyer.** No, Mr. Chairman.

Mr. **Kildee.** You've been very, very helpful and very, very good. I appreciate it very much. I'm much more enlightened as of now because you were here today, and I appreciate it very much.

I will keep the record open for 2 additional weeks for any additional testimony.

[Whereupon, at 12:46 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows:]

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COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
[illegible] CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515

SUBCOMMITTEE ON HUMAN RESOURCES

April 7, 1987

Dolores Battle, Administrator
Office of Job Training Programs
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Dear Ms. Battle:

This letter is to follow up on one of the issues raised during your testimony at the Subcommittee's April 6 hearing on the reauthorization of the Older Americans Act.

I would appreciate your submitting for the hearing record a list of the specific criterion used to grant waivers of the Title V administrative cap.

This information will be useful to the Subcommittee as it considers proposed changes in this vital legislation.

Your assistance in this matter is greatly appreciated.

Sincerely,

Dale E. Kildee
Chairman

mk

U.S. Department of Labor

Employment and Training Administration
200 Constitution Avenue, N.W.
Washington, D.C. 20210

29 APR 1987

The Honorable Dale E. Kildee
Chairman
Committee on Education and Labor
Subcommittee on Human Resources
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your letter of April 7 following up on my testimony before the Subcommittee's April 6 hearing on the reauthorization of the Older Americans Act. As you requested, the following is a discussion of the criteria used by us in consideration of requests for waiver of the Title V administrative cap.

The criteria used for review of administrative cap waiver requests are an extension of the criteria used annually for the review of the Title V sponsors' grant applications. These reviews during the annual funding process provide us with specific areas for negotiation of grant costs with individual sponsors.

In reviewing administrative costs, the general factors considered are (1) if there are increases in costs in excess of the current year's effort, (2) whether efforts were made to reduce costs as required by the legislation to the statutory cap limit, and (3) whether further reductions to less than that level would affect adversely the efficiency of the project. These general factors are then distilled into more specific criteria such as:

- o What increases in costs, if any, are due to factors over which the sponsor has little or no control, e.g., liability insurance, worker's compensation, and audit costs;
- o What increases are proposed that are discretionary in nature and are in excess of normal inflation, e.g., salaries and fringe benefits;
- o What increases are proposed and the justification for them for supportive costs, e.g., the procurement of services, equipment, supplies, leases, telephones, printing, and technical assistance; and

- o Would there be adverse results if further cost reductions were required, e.g., the consolidation of projects which might limit the geographic scope of the sponsor's program and its equitable distribution efforts, the reduction of job development staff which would make the higher unsubsidized placement rate of 20 percent more difficult to achieve, or the reduction of staff engaged in providing technical assistance or the monitoring of subcontractors to determine compliance with accounting and other regulatory requirements.

Since reviews are based on an analysis of each grantee's own past expenditure patterns and budget, they necessarily consider variables such as the grant amount, rural versus urban projects and the grantee's method of operation, e.g., direct administration or subcontracting, minority oriented and directed, etc. These factors are weighed against budgetary line items. In each case, we recognize that these are projected costs and that subsequent end-of-year grant expenditures tend to be historically lower than the budget negotiated.

We anticipate that our negotiations with each grantee for Program Year 1987 will be completed by June 15 and that each grant will be funded and operational on July 1, 1987.

I hope this information satisfactorily responds to your request. If you should need more specific information, please have a member of your staff contact Mr. Paul A. Mayrand, Director, Office of Special Targeted Programs at 535-0500.

Sincerely,

Dolores Battle

DOLORES BATTLE
Administrator
Office of Job Training Programs

THE UNIVERSITY OF MARYLAND
CENTER ON AGING

The National Center on Aging and Disabilities

6 April 1987

Congressman Dale Kildee
Subcommittee on Human Resources
320 Canon Building
Washington, DC 20515

Dear Congressman Kildee:

I would like the following information to become part of the hearing record for April 6, 1987 on the reauthorization of the Older Americans Act. I have purposefully made my written testimony short, and have included a number of attachments which I hope will interest your staff, and which you may want to include for the record.

My name is Dr. Thomas Rose. I am a Research Associate at The National Center on Aging and Disabilities, Center on Aging, University of Maryland, College Park, Maryland 20742. For the past two years we have concentrated our efforts on understanding and planning for the needs of elderly persons with developmental disabilities and mental retardation.

With my associates we have written a number of articles about Older Developmentally Disabled Adults. We have been especially concerned with the plight of this underserved vulnerable minority. You will find useful statistics and other information in the attached article, and in an article that I have written for the Spring 1987 issue of Aging published by the Administration on Aging. In addition, with my associates, we have presented papers about older developmentally disabled citizens at a number of national and state conferences including: The Gerontological Society of America, The Orthopsychiatric Society, The Association for Gerontology in Higher Education, The Young Adult Institute, etc.

With funding from the Maryland State Planning Council on Developmental Disabilities, we have just completed an 18 month research and planning study about aging and developmental disabilities in Maryland. We have placed emphasis on the policy and programmatic implications as developmentally disabled citizens grow older. Our final report will be available in late April, 1987.

As part of the Maryland study, The National Center on Aging and Disabilities at the Center on Aging has established a National Aging and Developmental Disabilities Information Exchange which offers information on demonstration and model projects, bibliographies, and other materials. I have attached some of these materials with this testimony.

COLLEGE PARK CAMPUS
Room 1120, Francis Scott Key Hall
College Park, Maryland 20742-7321 (301) 454-5856

With the support of a number of foundations and organizations we have organized a national conference on Aging and Life long Disabilities: Partnership for the Twenty First Century in June, 1987 at the Wingspread Conference Center in Racine, Wisconsin. The participants will include state directors of aging and state directors of developmental disabilities/mental retardation, and representatives of a number of national aging and disability organizations. The cosponsors of this conference include, among others: The National Association of State Units on Aging, The National Association of State Mental Retardation Program Directors, The Joseph P. Kennedy Foundation, and the National Institute on Aging. The final report of this conference will be practical and policy oriented, and distributed to more than 3000 organizations and individuals in the fields of aging and developmental disabilities. I have attached an agenda and summary about the conference.

Finally, the Center on Aging has focused on education and training as more aging developmentally disabled persons are served by the aging and developmental disabilities networks. We have developed a state-wide conference, curriculum materials, two day work shops, bibliographies and resource materials, and have submitted a major training proposal to the Department of Health and Human Services.

If there is any way we can assist your committee, please call on us at anytime. Thank you for making this testimony part of the record.

Sincerely,

Thomas Rose

Thomas Rose, Ph.D.
Research Associate

RELATED MATERIALS MAY BE FOUND IN SUBCOMMITTEE FILES.

National Governors' Association

Bill Clinton
Governor of Arkansas
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT OF

THE HONORABLE EDWARD D. DIPRETE
GOVERNOR OF RHODE ISLAND

on behalf of

THE NATIONAL GOVERNORS' ASSOCIATION

before the

SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

regarding

REAUTHORIZATION OF THE OLDER AMERICANS ACT

March 23, 1987

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001-1572 · (202) 624-5300

148

Mr. Chairman and Members of the Subcommittee, I very much appreciate the opportunity to submit testimony for the record on behalf of the nation's Governors regarding the Older Americans Act (OAA). I am particularly delighted to be submitting this testimony because Rep. John Fogarty of Rhode Island was one of its principal sponsors when it was enacted in 1965.

The National Governors' Association strongly supports reauthorization of the Older Americans Act. While other federal programs serve the elderly, NGA believes that the Older Americans Act is essential in the continuum of services for the elderly. The Governors therefore are pleased to see a general consensus that the basic OAA programs for social services, nutrition and employment should be continued at least at current levels of funding.

The Governors believe, however, that the Older Americans Act must change as America's elderly population increases as a proportion of the population, particularly with larger numbers over age 85. While many of the new elderly may be healthy, a growing number, particularly those over 85, will need more help with activities of daily living.

To respond to the needs of this growing group, the Governors have called for a new authorization in Title III of the act to strengthen state efforts to provide in-home services to the elderly. To complement this suggestion, NGA believes that the Older Americans Act should increase support to prevent the problems that lead to functional impairment. Finally, we ask for the authority to develop cost-sharing arrangements with those elderly who are able to pay for services.

NGA commends the chairman for including the first proposal in his bill to reauthorize the OAA, H.R. 1451. We look forward to working with the chairman and the members of the subcommittee to see enactment of this proposal along with the other NGA proposals.

There are three compelling reasons to increase OAA support for in-home services to the frail elderly:

- First, in the year 2010, there are expected to be 7.1 million more elderly over age 75, including 3.9 million over age 85, than in 1985. Moreover, in 2010, the life expectancy at age 65 is expected to be 86.1 for females and 81.1 for males. The elderly population will increase to about 21 percent of the population in the year 2030, up from 12 percent in 1985. About 16 percent of the elderly will be over age 85, up from 9 percent in 1985.

- Second, the new Medicare prospective payment system may be resulting in some patients being discharged sooner and in poorer health than before. The length of stay for all Medicare short-stay hospital discharges in fiscal 1984 was 9 percent lower than in fiscal 1983. The testimony before this Subcommittee on July 30, 1985, by experts in the field of aging clearly shows that they believe that the prospective payment system in Medicare is increasing demand for in-home services due to early releases of patients from hospitals.

- Third, it is clear that over the next several decades the number of elderly with functional impairments will increase. The 1982 National Long-Term Care Survey showed that approximately 4.6 million elderly living in the community needed help with at least one activity of daily living, including about 1 million who exhibited severe functional impairments in performing such activities as cooking, dressing, bathing, and getting into and out of bed. The survey found that these needs increased with age: about 12.6 percent of persons age 65-74 needed such assistance, but about 46 percent of those over 85 needed it. The General Accounting Office reports that researchers forecast that from 1980 to 1995, the number of elderly with disabilities will increase 45 percent, and the most severely disabled group by 49 percent.

We suggest that the new authorization in Title III take into account factors such as the number of elderly over age 75 and over age 85, the estimated number suffering from Alzheimer's and related diseases, the number of elderly who are impaired in three or more activities of daily living, and the number of elderly who are minorities. In addition, we believe states should use these and related factors when determining who is eligible to receive in-home assistance under this new authorization. Moreover, we believe all other Title III requirements and options should apply to this new part.

The Governors also urge you to increase Older Americans Act support for preventive health services. We are convinced that preventing the need for intensive health services is not only cost-effective, but compassionate. Title VII of the act, which has not been funded since it was added to the OAA in 1984, could be restructured to provide federal matching funds to states for preventive health services. A specific package of preventive services, including physical examinations, influenza vaccinations and appropriate testing, screening, and health education is envisioned. Leading health problems that cause functional impairments in daily living -- arthritis, hypertensive disease, hearing, dementia, and musculoskeletal diseases -- may be reduced through preventive services. To increase accessibility, NGA policy suggests that such services be provided through senior centers.

The Governors' third major proposal is to permit state initiatives to develop new resources for OAA programs. It is time to recognize that the elderly with high incomes can share in the cost of services they receive, and that states can use the increased revenue to serve more elderly. States should be permitted to develop cost-sharing approaches for services other than nutrition programs. These arrangements should be on a sliding scale based upon ability to pay.

This approach is not new. In fact, cost-sharing is an accepted practice in Medicare and many state-financed programs for the elderly. The Illinois Community Care Program is an excellent example of a program that charges on a sliding scale for services such as homemaking and adult day care. This program sets a threshold income level below which no fee is charged. Of the 25,000 persons receiving services from the program, half are below the threshold. The half above the threshold are charged for services.

States should be permitted to continue to seek voluntary contributions for meal programs and social services. Rhode Island, for example, has an excellent record in soliciting voluntary contributions for the senior nutrition program. During fiscal 1986, older persons contributed an average of 90 cents for every meal served.

In addition to these new initiatives, the Governors want to maintain and/or strengthen the current services and research funded through Titles III, IV, and V of the act. Our specific recommendations are:

- To maintain current federal law which does not target through set-asides, or interstate or intrastate funding formulas.

- To retain the Governors' responsibility to structure the long-term care ombudsman program to assure its independence and integrity. We would support a provision in Title III to permit states that fund the ombudsman with state funds to waive the set-aside requirement, as long as state funding at least equals the set-aside amount.

- To maintain the state responsibility for coordination and integration of community-based, long-term care services. We particularly oppose eliminating state authority to decide whether or not to authorize Area Agencies on Aging to provide direct services, such as case management. Rhode Island and six other states do not have area agencies, but administer programs under one state agency. However, we are most sensitive to the needs of the other 43 states, and their need to retain this authority. The Governors believe that the state role in the OAA network is to first and foremost coordinate services among state, local, and private sector programs, and to prevent duplication. This should be continued.

- To require that the national contractors and state agencies operating Title V community service employment programs develop a statewide plan, to be approved by the Governor. National contractors should not have the sole discretion to determine the location of community service job slots for the elderly within states. The state agencies on aging should be co-equal partners in these decisions, and the Governor should approve a written agreement among all contractors and the state. This procedure will assure coordination with other jobs programs and should lead to a fair distribution of job opportunities throughout each state. In states where relations between the aging agency and the contractors are congenial, obtaining gubernatorial approval should not be a problem. The need for this simple and logical procedure is evident when one realizes that in 31 states, there are four or more national contractors operating independent programs. In Pennsylvania alone, there are eight contractors, and three states each have seven national contractors. While in some states the contractors may have a good working relationship with the state aging agency, we believe there is a need to formalize the relationship in writing.

- To require state input into federally financed research and demonstration projects funded through Title IV. We believe that research and demonstration projects should support innovative approaches to services and encourage new approaches to intergenerational activities that better integrate the elderly into society.

I want to thank you again for permitting the National Governors' Association to submit testimony for the record. We look forward to working with you to find solutions to the long-term care needs of America's growing elderly population. We believe that a vibrant aging network--with new authority for in-home and preventive health services and authority to secure new resources--in a reauthorized Older Americans Act is an excellent first step. We offer our help and assistance with this reauthorization effort.

Statement on the
Intergenerational Day Care Amendment to Older American's Act
Older Americans Act Reauthorization Hearing
by Congressman Mickey Leland
April 16, 1987

Mr. Chairman, I have been working on an amendment to your Older Americans Act involving intergenerational day care. This is a small program, however, such a catalyst is needed to increase the prevalence of intergenerational day care in our country.

In our society today, we have a situation where the proportion of older persons is increasing. These elders are better educated and in better health than any group in the past and many of them desire employment.

Simultaneously, we are facing an increasing number of working couples with children as well as single mothers who must work outside the home to support themselves and their children. These parents rely increasingly on child care services.

Uniting older persons and children in child care centers provides elders with an opportunity for meaningful employment and provides children with unique child care providers.

Under this amendment, grants shall be available to the eight national sponsors currently participating in the Title V program to carry out intergenerational child care projects. The grants shall be applied for and awarded on a competitive basis.

Some of the provisions under this amendment include the following: all projects must be licensed to provide child day care, educational and inservice training are to be provided, all service providers must demonstrate medical fitness by obtaining an annual physical examination, and a sliding scale to charge fees based on ability to pay shall be used to the extent practicable. Each project is to be monitored and the evaluations analyzed. The resulting information is to be used to compile a guidebook for the operation of child day care projects that employ eligible individuals to provide child care services.

Mr. Chairman, as stated in the Older American's Act itself, the intent is to further the purposes and goals of the program, one of which is to "contribute to the general welfare of the community." This is one area where every portion of our society's spectrum benefits: The employed elderly, the working parents, and the children themselves.

I look forward to working with you and other members of this Subcommittee on this amendment. Thank you.

PAUL B. HENRY
5TH DISTRICT, MICHIGAN

COMMITTEE ON EDUCATION
AND LABOR

COMMITTEE ON SCIENCE
AND TECHNOLOGY

SELECT COMMITTEE ON AGING

Congress of the United States
House of Representatives
Washington, DC 20515

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ANNE KNOX
DISTRICT ADMINISTRATOR

215 Cannon House Office Building
Washington, DC 20515
(202) 225-3831

MARY F LOBISCO
ADMINISTRATIVE ASSISTANT

April 3, 1987

The Hon. Dale E. Kildee
2262 Rayburn House Office Building
Washington, D.C. 20515

Dear Dale:

I know that you are currently in the middle of hearings on the reauthorization of the Older Americans Act. I would be grateful if the enclosed material could be made part of the record of those hearings.

I should indicate that the author of this letter is not only a County Commissioner in Barry County, half of which is in my District, but has also served as Chairperson of the Board of Directors of the Community Action Agency of South Central Michigan. She was also honored as the Elected Official of the Year last year by the Michigan Community Action Agency Association.

After working with Rae on the problems they have encountered with one of the national contractors under Title V, I asked her to write up a summary of their experiences at the local level, so that this perspective could be included in the Committee's consideration.

Of course, I would also be pleased to work with your staff in seeking to address these concerns during the reauthorization process.

Thanking you in advance for your assistance, I am

Sincerely yours,

Paul

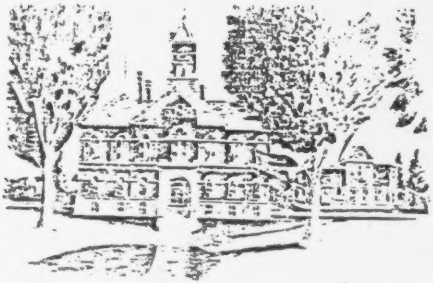
PAUL B. HENRY
Member of Congress

PBH:ej

Enclosure

cc: Susan Wilhelm
Carol Lamb

Barry
County
Court House



March 16, 1987

Honorable Congressman Paul Henry
502 Cannon
House Office Building
Washington, D. C.   20515

Dear Paul:

Thank you for your recent letter regarding the Title V Senior Aides Program. The information generated through the Library of Congress, Congressional Research Service was especially helpful in providing answers to many of the questions I raised regarding the authority wielded by the National Council of Senior Citizens (NCSC) in their administration of this program.

The information does, however, raise several issues which may warrant your attention as the Older Americans Act and Title V are reviewed in the upcoming year. Given our very disappointing local experiences with the National Council of Senior Citizens, I would hope you can effect changes which will lead to a more sensitive and thoughtful administration of the Title V Projects in future years. Please consider the following:

① Administrative Funding - As your research points out, there is a statutory limitation on the amount of federal funds which may be used for administration of Title V projects, but each national contractor, however, may determine how (or if) those funds are distributed. NCSC passes no administative funds on to local operators. I can think of no other federal program with such a strident and outdated approach to project administration. I agree that cost sharing between the federal government and local communities is often desirable, but I cannot accept the idea that locals should bear all the cost of administration. These are the toughest funds to raise and sustain year after year for local sponsors, many of whom are community based organizations already rocked by recent cuts in support for human service programs. I can point to dozens of examples of federal/local cost sharing projects where the local community is not required to come up with 100% of the administrative cost, but can meet its match obligation by providing other programmatic funding. Numerous federally funded projects in the aging, health care, transportation and housing areas speak to the widespread acceptance and effectiveness of this, more flexible, cost sharing approach.

The unwillingness of NCSC to share administrative funding at the local level has also caused significant instability and disruption among sponsoring agencies and seniors enrolled. In the last eight years there have been three different local sponsors of the major Title V employment project in this area. Each of those sponsors relinquishing the program did so because they were unable to come up with the local cash match for administration required by NCSC. The last change resulted in the Senior Aides project being eliminated locally and replaced by the AARP administered Senior Employment Project, to the confusion and detriment of many low-income, at risk seniors who lost health benefits in the transition.

If the administrative funds held by NCSC were just too limited to pass on it might make their "no share" policy more palatable. They do, however, have at their disposal up to 13.5% of the federal allocation for administrative costs. This in the past has enabled NCSC to fly monitors from Washington into local programs quarterly while other federal programs such as Head Start and Fostergrandparents have annual visits from regional federal offices. On one occasion last fall NCSC flew two employees from Washington to Battle Creek on the same day via different routes. One flew into Kalamazoo, rented a car and drove to Battle Creek, while the other flew into Detroit, rented a car and drove to Battle Creek. Perhaps they felt a need to surround the local sponsor, entering from the east and west simultaneously in a sneak attack. I realize we need to use caution when generalizing about national policy from specific instances of administrative excess, but that's all we're allowed to see at the local level and we've seen far too much to be comfortable that the NCSC approach is cost efficient.

NCSC uses some portion of its administrative funding to sponsor a national conference with all expenses paid for local project directors. It seems counterproductive to spend administrative funding for hotel rooms, airfares and meals when all across the country projects are scraping to meet their basic and fundamental administrative needs.

In the long run, we've learned that in human services like many other areas, you get pretty much what you pay for. In the case of the Senior Aides Program we've gotten a bloated national contractor and a highly unstable administrative environment. Congress could rectify this by requiring that local sponsors receive sufficient administrative funding from NCSC. They may have to tighten their belt to make it happen but from what I've seen it wouldn't hurt them to do so and the real winners would be the low income seniors the project is intended to serve.

② NCSC Autonomy - We also discovered that NCSC answers to no one but the Department of Labor and even then only by way of a contractual relationship which gives broad discretion in the actual conduct of the program. As I related to you earlier, the three commissions in the counties formerly served by the NCSC Senior Aide Program, were essentially powerless to impact NCSC decisions. I can think of no other human

Honorable Congressman Paul Henry
March 18, 1987
Page Three

service program where local people are so far removed from the decision making process. The Regional Commission on Aging, the CAA and the JTPA delivery systems all require local participation in the design and conduct of their programs. NCSC on the other hand has nearly total autonomy to make decisions, without regard to local preferences or needs. The recent swap of Senior Aide slots for AARP slots, which occurred in our area, was accomplished against the best advice of the County Commissions, local service agencies and the affected seniors, many of whom suffered significant losses in the process.

The new federalism of the last six years has encouraged greater involvement of local units of government in a wide number of program and issue areas. I'm surprised Congress continues to allow the renegade autonomy of NCSC to fly in the face of this new partnership.

In closing, I appreciate your attention to these concerns and although the damage has already been done in our area, I would hope changes could be made which will correct the reckless administration of Title V programs in other parts of this state. Please let me know if additional information would be helpful.

Warm personal regards,

Rae

Rae M. Hoare
Commissioner, Barry County

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Statement on

REAUTHORIZATION OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

HOUSE COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEE ON HUMAN RESOURCES

Submitted by

ROGER P. KINGSLEY, Ph.D.

DIRECTOR, CONGRESSIONAL RELATIONS DIVISION
GOVERNMENTAL AFFAIRS DEPARTMENT
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

April 6, 1987

10801 Rockville Pike, Rockville, Maryland 20852 (301) 897-5700

As the professional and scientific association representing over 52,000 speech-language pathologists and audiologists nationwide, the American Speech-Language-Hearing Association (ASHA) is very concerned about services to elderly people with communication disorders. We are pleased that, as part of the reauthorization of the Older Americans Act, the Subcommittee on Human Resources is planning to examine the problems of people with disabilities who are or should be served under the Act.

Provisions in Current Law on Health Care Services to the Elderly

A major objective of the Older Americans Act of 1965, as amended (P.L. 89-73) (Section 101 (2)) is "The best possible physical and mental health which science can make available and without regard to economic status." Another objective is to make it possible for elderly people to receive health and social services in institutions where necessary and in their communities whenever possible through (Section 101 (4)):

> "Full restorative services for those who require institutionalized care, and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes."

The basic grant program, Title III, provides for services to older individuals "with the greatest economic or social needs," and defines social need (Section 305 (d)(2)) as:

> "the need caused by noneconomic factors which include physical and mental disabilities, language barriers, and cultural or social isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens his or her capacity to live independently."

The Act also provides for supportive services, such as personnel training and research, which are necessary for appropriate and effective implementation of basic health care services to elderly people, particularly those with disabilities. A major purpose in Title IV (Section 410) is:

> "to improve the quality of service and to help meet critical shortages of adequately trained personnel for programs in the field of aging by--
>
> (1) identifying both short- and long-range manpower needs in the field of aging; (2) providing a broad range of educational and training opportunities to meet those needs; (3) attracting a greater number of qualified personnel into the field of aging; (4) helping to upgrade personnel training programs to make them more responsive to the need in the field of aging; and (5) establishing and supporting multidisciplinary centers of gerontology and providing special emphasis that will improve, enhance, and expand existing training program."

ASHA believes that the foregoing objectives of the Act require Congress to take a close look, during the present reauthorization, at the adequacy of services and personnel providing services to older Americans. This statement focuses on the problems and needs of elderly persons with communication disorders and the workforce available and needed to attend to this large and growing population.

Communication Disorders Among the Elderly

The rapid aging of the American population is by now a well known fact. U.S. Census data for 1985 showed that a total of 28.5 million people are 65 years or older, representing 12% of the population.[1] It is projected that the elderly population will more than double to 65 million people by the year 2030. One in five Americans will be elderly.[2] The groups among the elderly with the most rapid growth will be the "oldest of the old" -- women and racial minorities -- the same groups that suffer the most from problems of poor health, poverty, and social isolation.

Among the most prevalent health problems in the elderly population are speech, language and hearing impairments. Many of these problems are associated with diseases that occur among adults and which may be directly related to the aging process: Alzheimer's disease, a principle cause of dementia; Parkinson's disease and other progressive neurological diseases resulting in oral-motor dysfunction; stroke, resulting in aphasia or the loss of speech and language ability; cancer of the larynx, resulting in laryngectomy; and, presbycusis, or degeneration of the auditory function associated with the aging process. The impact of these conditions on human communications is apparent. Stroke typically impairs the individual's ability to interpret and use language symbols for listening, speaking, reading and writing. The more than one million older persons with severe forms of senility and the estimated two million other senior citizens exhibiting moderate senility typically demonstrate language impairment. Reading comprehension and understanding of oral speech are reduced.[3] One study indicated that only 5% of senile patients had adequate communication ability.[4] Since the prevalence of senility increases with advancing age, the problem will become greater as the number of the very old expands at the projected rate. The number of older Americans being maintained at home or who are deinstitutionalized and returned to the community is also increasing. Many of these people are mentally retarded or otherwise developmentally disabled, and a majority of this population has communication disorders.[5]

The Department of Health and Human Services estimates that at least 25% of persons between 65 and 74 years of age have hearing impairment, twice the occurrence for people in the 65-64 age group. In the 75 years and older population this figure jumps to over 40%. In 1980, the proportion of people 65 years and older with hearing and speech disorders were 43% and 20% respectively, but will grow to 46% and 25% by the year 2000, and to 59% and 39% by 2050.[6]

Older Americans experience multiple problems -- physical limitations, chronic health conditions, lack of economic resources, and loneliness. At a time in their lives when there is a growing need for interpersonal communication, many elderly individuals are affected by conditions that profoundly limit their communicative abilities. These individuals may be unable to share perceptions and memories, inform others of their needs, or continue to take part in vocational, social and recreational activities. Most seriously, the social isolation occasioned by communication disabilities may lead to psychopathology.[7]

Hearing loss results in difficulties in understanding oral speech, particularly in noisy environments. When this occurs in older persons, there is a tendency for friends and even family to view the individual as becoming senile because of inappropriate responses and confusions that may arise. An expert in hearing problems describes the many ways in which hearing loss in older persons negatively affects their daily lives:

> One can understand the fear, apprehension and confusion an older hearing impaired person must experience as a hospital patient trying to determine what is going on; or the frustration of half-heard movies, plays and lectures; the disappointment of not being able to have the full worship experience at church or synagogue; the embarrassment and problems resulting from missed announcements from a public address or paging system in an airport, bus station, train station, or doctor's office; the problems that arise at home when food boils over, bathtubs overflow, and timers, alarm clocks, doorbells and telephones are not heard; the loss of independence due to greater difficulty making telephone calls or driving a car; the potential loss of calming influences and pastime activities, such as

> listening to music, hearing the quiet sounds of nature while on a walk, watching television, dining out, going shopping; the sense of tension and anxiety at parties or when entertaining guests because of the difficulty coping with the background noise and the conversational banter. When such experiences and feelings are considered, it is not surprising that an older person who has a hearing impairment is tempted to give up and withdraw defeated, discouraged, disappointed and dismayed. It is difficult enough to deal with such problems in a friendly and understanding environment, but too often the older person encounters a somewhat hostile environment lacking in understanding and patience.[8]

The prevalence of hearing loss among nursing home residents has been reported in the range between 48% to 82% and approximately 25% of the elderly in nursing homes have speech/language impairments.[9] While the number of older Americans in long-term care facilities continues to grow, the number in community and home based settings is also increasing as a result of the move toward deinstitutionalization.

Availability of Services for the Communicatively Impaired Elderly

Most elderly people are covered through Medicare or Medicaid, although the settings in which reimbursable services can be provided varies a great deal. Physician services related to the diagnosis and treatment of hearing impairment are covered as are diagnostic services by audiologists when evaluations are requested by a physician to determine the cause of a hearing disorder. Rehabilitative services provided by audiologists are provided for patients under certain circumstances. However, hearing aids and evaluations for such aids are not covered by Medicare and are covered in only about half of the states under Medicaid. Speech-language pathology services are covered in a various inpatient and outpatient settings including hospitals, skilled nursing facilities, speech and hearing clinics, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, and home health agencies.

Hearing services for elderly persons are provided primarily in the offices of physicians, audiologists, and hearing aid dealers. To a lesser extent, hearing services are provided in health care and educational settings and in multi-service community agencies. Most hearing services provided by health care institutions are delivered on an outpatient basis, with the emphasis on short-term care. Home health programs offer an optimal setting for the delivery of services to the communicatively impaired elderly, but these services are not generally available. In a study of 206 home health agencies, only 5% provided hearing services.[10] Adult day care centers that serve people who require long-term care but reside at home are another appropriate setting, for service delivery. Some senior centers which offer social services also offer hearing screening and other hearing services.

Elderly individuals who experience speech, language and/or hearing disorders can often maintain a high degree of independence through the use of communication aids and devices. The most common device used by the hearing impaired elderly is, of course, the hearing aid. Assistive listening devices (e.g., audio loops, telephone amplifiers) often enable individuals to hear television and radio, to follow what is being said in large areas and even noisy environments, and to communicate on the telephone. Individuals with speech and language impairments can often benefit by using augmentative communication aids such as communication and language boards and electronic and microcomputer equipment. However, these forms of assistance are often unavailable to the communicatively impaired elderly because service facilities are not informed of their benefit to the potential user. A survey of facilities that provide communication aids to severely speech impaired individuals found that barely half provided services to the elderly.[11]

Research concerning services to elderly persons with communication disorders and supported by Title IV grants is currently being conducted by a number of institutions (including Gallaudet University, The Urban Institute, and United Way of America) which focuses on health service needs and personnel requirements of the elderly population.[12] A recently published study by the Gallaudet Research Institute reports that approximately 9% of senior centers surveyed nationally had special programs and services for elderly hearing impaired persons. Common types of support services and equipment for elderly persons included hearing testing and screening, hearing aid sales and service, telephone devices for the deaf (TTDs and TTYs), speech reading and auditory training.[13]

Personnel Available and Needed to Serve Elderly People with Communication Disorders

As the number of older Americans continues to grow, health care services and qualified personnel to provide these services must also necessarily increase. The need for professionals to provide services to the communicatively impaired elderly must take into account the prevalence of speech, language and hearing disorders, population size, practice settings and delivery systems.

Speech-language pathologists and audiologists are individuals certified and licensed (in 36 states for speech-language pathologists and 37 states for audiologists) to provide professional assistance to persons of all ages with communication disorders. These professionals offer important services to elderly people with primary or secondary communication disorders. Speech-language pathologists provide many specialized services such as (a) helping the aphasic patient to relearn language and speech skills; (b) helping the laryngectomized individual learn an alternative to the normal way of speaking, particularly through the use of augmentative communication devices; and (c) counseling individuals and families with speech and language problems. Audiologists specialize in (a) preventing, identifying, and assessing hearing impairment; (b) rehabilitating the hearing impaired; and (c) fitting hearing aids and training individuals in their use.[14]

Because of changing demographics in the elderly population and the dynamics of the health care system, the actual number of speech-language-hearing personnel that will be needed to provide services to the elderly can only be estimated. At present, ASHA is conducting a work force study which is looking at the current and projected supply of and demand for speech-language-hearing personnel to serve people with communication disorders. Since the results of this study will not be available for a while, the estimates presented here are based on limited data and tentative projections.

ASHA estimates that the supply of speech-language pathologists and audiologists will increase from the current level of about 48,500 to approximately 75,000 in the year 2000. Certified members of the profession must hold at least a master's degree and have had a year of supervised clinical experience in speech-language pathology and audiology. Work force projections can be made by examining the numbers of students entering and graduating from training programs and by examining changes in the supply of professionals providing services. The number of master's degree entrants into the profession has fluctuated around 15% over the past five years. Since this group provides the majority of clinical services, a steady but still inadequate influx of new professionals will be available for service to elderly persons with communication disorders. However, the profession is experiencing a serious drop in the number of doctoral degree students. Since this group forms the majority of faculty members involved in personnel preparation programs, fewer will be available to teach incoming students.

The figures in the accompanying charts represent lower and higher estimates of speech-language pathologists and audiologists needed to serve the elderly, based on the prevalence of communication disorders in the 65 and older population and professional practice patterns including patient caseloads.[15]

Currently, ASHA surveys indicate that over 12% of the caseloads of speech-language pathologists and approximately 3`% of the caseloads of audiologists consist of elderly individuals.[16] As the accompanying tables show, the number of professionals needed to serve this population ranges between about 11,000 and 73,000 and 5,750-9,500, respectively for speech-language pathologists and audiologists. Within the next 35 years, the number of professionals needed to work with elderly individuals will approximately double.

Recommendations

ASHA's recommendations for the Older Americans Act focus on services, benefits, and training related to elderly individuals with communication disorders. Some of the proposals have been developed in consultation with other professional provider associations, organizations representing the disability community, and senior citizen organizations. We believe that it is imperative that Congress recognize the increasing prevalence of communication problems among the elderly, the resultant need for more qualified professionals to serve this population, and the need to increase access to services and the availability of benefits such as hearing aids and augmentative communication devices. We are cognizant, however, of limited authorizations and current budget restraints. Therefore, several of our recommendations are for modest expansion of training and demonstration projects under Title IV as opposed to broader expansions under Title III.

Recommendation for Title II

In order for the Administration on Aging to be more aware of and involved in issues concerning elderly people with disabilities, a new subsection should be added to Section 202 (a):

> "(19) Consult with national organizations representing the interests of persons with disabilities, including but not limited to developmental disabilities, including stroke, head injury, physical or sensory impairments, mental disorders, Alzheimer's disease and related disorders, to develop and disseminate information on population characteristics and needs, training of personnel, and to provide technical assistance designed to assist State and area agencies to provide services in collaboration with other state agencies to older persons with disabilities."

Recommendations for Title III

In order for state and area agencies on aging to focus more on the needs of elderly people with disabilities, two new subsections should be added as follows.

Amend Section 305 (a) (2) by adding a new subsection:

> "encourage the development of cooperative arrangements between State area agencies and state health agencies with primary responsibility for individuals with mental retardation, developmental disabilities, or other handicapping conditions, and encourage collaborative programs to meet the needs of vulnerable older individuals with these conditions."

Amend Section 306 (a) (5) concerning services to individuals with the greatest social needs, by adding a new subsection:

> "elderly with mental and physical disabilities, including but not limited to physical or developmental disabilities, stroke, head injury, physical or sensory impairments or Alzheimer's disease."

Recommendations for Title IV

The statement of purpose should be amended to include a reference to people with disabilities. A new subsection should be added to Section 401, relating to meeting the needs for trained personnel in the field of aging through:

> "collaborative projects joining aging with professions specializing in physical and mental disabilities."

A new section 413 should be created to enable the Commissioners of the Administration on Aging and the Administration on Developmental Disabilities to enter into cooperative agreements in order to establish multidisciplinary centers to train personnel to specialize in working with elderly developmentally disabled people.

> "The Commissioner in conjunction and agreement with the Commissioner of the Administration on Developmental Disabilities may make grants to private and public nonprofit agencies, organizations, and institutions of higher education for the purpose of establishing multidisciplinary centers in aging and developmental disabilities. Such centers shall conduct research and policy analysis, provide for the training of personnel, serve as a technical resource at the State level for State agencies, State developmental disabilities planning councils, State mental retardation/developmental disabilities agencies and service providers and at the national level, to the Commissioners and the Congress, and provide for other functions deemed necessary by the Commissioner. Such centers on aging and developmental disabilities shall --
>
> (1) develop and provide education programs for the training of personnel working with older developmentally disabled individuals; (2) conduct research on service practices; (3) provide technical assistance to State and area agencies providing for older individuals with developmental disabilities; and (4) serve as repositories of technical information."

Two new subsections should be added to Section 422, relating to special projects designed to "(2) meet the special health care needs of the elderly, including--

> "the identification and provision of services to elderly individuals, including individuals with lifelong disabilities, with

> disorders of speech, language and/or hearing that interfere with their ability to function socially and independently; and
>
> the provision of rehabilitative services, and communication aids and devices, to assist individuals, including individuals with lifelong disabilities, with speech, language and/or hearing disorders."

In addition, we note that, while the Act makes reference to "qualified personnel," there is no definition of this term in the regulations implementing the Act. Currently, there is a lack of data on the qualifications of personnel providing health care services under the Act. However, the Older Americans Act Amendments of 1984 included a provision requiring the Commissioner to (Section 421 (c)) "identify the future needs of older individuals; identify the kinds and comprehensiveness of programs required to satisfy such needs; and identify the kinds and number of personnel required to carry out such programs." We, therefore, urge the Committee to give careful consideration to the findings with respect to the supply and qualifications of health care professionals working in the field of aging.

Notes

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3. American Speech-Language-Hearing Association, *Communication Disorders and Aging* (1985), p. 23.

4. Ferm, L. "Behavioral Activities in Demented Geriatric Patients," *Gerontology*, 16, (1975), p. 185.

5. Committee on Mental Retardation/Developmental Disabilities, ASHA Position Statement, "Serving the Communicatively Handicapped Mentally Retarded Individual," *Asha* (August 1982), pp. 548-49.

6. Fein, D. "Projections of Hearing and Speech Impairments to 2050," *Asha*, 25, (1983), p. 31.

7. ASHA, *Communication Disorders and Aging*, p. 24.

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9. National Center for Health Statistics, unpublished data from the 1973-74 Nursing Home Survey, in *Asha*, *The Prevalence of Communicative Disorders* (1981), p. 43.

10. Office of Technology Assessment, *Hearing Impairment and Elderly People* - A Background Paper (1986), p. 54.

11. Blackstone, S. and Isaacson, R. "Service Delivery in Augmentative Communication," in L. Bernstein (ed.), *The Vocally Impaired* (in press).

12. Administration on Aging, *Active Grants Under Title IV of the Older Americans Act*, Appendix VI (September 30, 1986).

13. Sela, I., *A Study of Programs and Services for the Hearing Impaired Elderly in Senior Centers and Clubs in the U.S.A.*, Gallaudet Research Institute (1986), pp. 142-49.

14. American Speech-Language-Hearing Association, *Communication Problems and Behaviors of the Older American* (1979).

15. Cherow, E., American Speech-Language-Hearing Association, Report to the National Institute on Aging on Meeting the Needs of the Communicatively Impaired Aging Population (1986).

16. American Speech-Language-Hearing Association, Omnibus Survey (1986).

Lower and Higher Estimates of the Number of Audiologists Needed to Serve the Elderly Population

	Population in Thousands			Population with Hearing Impairment (HI)			No. FTE Audiologists Required to Serve HI Population
Year	65-74 yr.	75+yr.	Total	65-74 yr.	75+ yr.	Total	Total
				Lower Estimate			
1980	15,627	10,265	25,892	4,094,274	3,717,983	7,812,257	5,755
2000	18,334	17,918	36,252	4,803,508	6,489,900	11,293,408	8,320
2020	30,093	22,560	52,653	7,884,366	8,171,232	16,055,598	11,828
				Higher Estimate			
1980	15,627	10,265	25,892	4,375,560	4,927,200	9,302,760	9,541
2000	18,334	17,918	36,252	5,133,520	8,600,640	13,734,160	14,086
2020	30,093	22,560	52,653	8,426,040	10,828,800	19,254,840	19,749

FTE = Full-time equivalent

Lower and Higher Estimates of the Number of Speech-Language Pathologists Needed to Serve the Elderly Population

	Population in Thousands			Population with Speech-Language Impairment (SLI)			No. FTE S/L Pathologists Required to Serve SLI Popul.
Year	65-74 yr.	75+yr.	Total	65-74 yr.	75+ yr.	Total	Total
				PRODUCTIVITY APPROACH **Lower Estimate**			
1980	15,627	10,265	25,892	129,704	87,253	216,957	11,126
2000	18,334	17,918	36,252	152,172	152,203	304,475	15,614
2020	30,093	22,560	52,653	249,772	191,760	441,532	22,643
				Higher Estimate			
1980						1,424,060	73,029
2000						1,993,860	102,249
2020						2,895,915	148,508

FTE = Full-time equivalent

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ASOCIACION NACIONAL P[illegible]ERSONAS MAYORES

REGIONAL CENTERS Los Angeles, CA San Diego, CA Washington, D.C. Miami, FL Chicago, IL New Orleans, LA Detroit, MI Philadelphia, PA

STATEMENT BY

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PRESIDENT/EXECUTIVE DIRECTOR

ASOCIACION NACIONAL PRO PERSONAS MAYORES

(NATIONAL ASSOCIATION FOR HISPANIC ELDERLY)

BEFORE THE

HUMAN RESOURCES SUBCOMMITTEE

HOUSE COMMITTEE ON EDUCATION AND LABOR

ON

REAUTHORIZATION OF OLDER AMERICANS ACT TITLE V

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

APRIL 6, 1987

National Association For Hispanic Elderly
National Executive Offices: 2727 West Sixth Street, Suite 270, Los Angeles, CA 90057 (213) 487-1922

Congressman Kildee and Members of the Human Resources Subcomittee, the Asociacion Nacional Pro Personas Mayores (National Association for the Hispanic Elderly) appreciates the opportunity to submit testimony for your hearing on the reauthorization of the Older Americans Act. As you have requested, the Asociacion will focus on the Title V Senior Community Service Employment Program (SCSEP).

Title V has been an extraordinarily effective program by any standard one would choose to use. In short, it has been a "win-win" situation for our nation, the older enrollees, and the communities that they serve. It has enabled low-income older Americans to help themselves while rendering valuable and needed services in their communities. Our nation has also benefited because many older Americans have been able to move off the assistance rolls and become gainfully employed taxpaying citizens.

Independent evaluators have reviewed Title V on numerous occasions and have always given the the SCSEP high marks. Title V enjoys strong bipartisan support in Congress, in large part because it has been administered effectively and efficiently. Administrative costs are low. Sponsors have fulfilled the program objectives. And, older workers have won the enthusiastic endorsement from agencies and people that they serve.

Title V has functioned effectively throughout its existence. It should be extended with increased authorizations and essentially fine-tuning changes.

A. Support for the Kildee Bill

The Asociacion wishes to express its support for two key provisions affecting the SCSEP in H.R. 1451, the 1987 Older Americans Amendments. First, H.R. 1451 would extend Title V for four years, through fiscal year 1991.

The Asociacion favors a long-term extension for the SCSEP and other Older Americans Act programs. We believe that all programs should be continued for at least four years, and preferably five years.

A long-term extension will provide greater continuity for Older Americans Act programs. It will also enable program administrators to plan their operations with adequate lead time. More importantly, it will provide a clear signal to older enrollees that Congress strongly backs the program.

Second, the Asociacion endorses the 5-percent annual increase in authorization levels for Title V in H.R. 1451, utilizing fiscal year 1987 as the base. This would enable the program to grow. Despite a great need, the SCSEP provides jobs for only about 1 percent of all potentially eligible older Americans. The evidence is very clear and convincing that there are many older Americans who are ready, willing and able to serve in their communities if given the chance. This takes on added importance now because poverty rose in 1985 for persons 55 years or older.

Increased authorizations are also necessary to account for anticipated operating costs. For example, an increase in the minimum wage appears likely in the near future. Social Security payroll taxes will rise again in 1988. Moreover, other operating expenses will probably increase, such as worker's compensation, rents, telephone costs, and others.

B. Continue to Emphasize Serving the Low-Income Elderly

One of Title V's primary goals, since its inception, has been to serve the low-income and hard-to-place elderly. Congressional sponsors developed Title V primarily to assist older Americans who were out of society's mainstream in terms of employment skills, education, and economic status. The SCSEP has been extraordinarily effective in providing a dignified way for disadvantaged older Americans to help themselves while helping others in their communities at the same time.

No other program has worked as successfully for downtrodden older workers as the SCSEP. In the opinion of the Asociacion, no other employment or training program has achieved as much as Title V for the amount of money expended.

The Asociacion reaffirms that the SCSEP should continue to emphasize that low-income and hard-to-place older Americans are primary targets for the program. One constructive way to clarify this important point is to insert language in section 502 stressing that the SCSEP is designed to serve unemployed low-income persons 55 years or older "who have poor employment prospects." This clause would make clear that Title V is designed to help the most disadvantaged persons in our society.

C. Opposition to Giving Governors Approval or Veto Authority

Our earlier remarks have stressed positive actions that can be taken to strengthen and perfect the SCSEP. The Asociacion is also concerned about a proposal to require national SCSEP sponsors to develop equitable distribution and statewide operation plans for approval by the governor of a state. Currently, the governor has review authority rather than approval or veto power. This existing arrangement, in the judgment of the Asociacion, has worked well, and should not be changed. Consequently, the Asociacion opposes the proposal on a number of grounds.

First, it assumes that a problem exists for equitable distribution of Title V positions. We strongly disagree with that assumption. Equitable distribution of enrollees, in our opinion, is not a problem. Our experience reveals that states and national sponsors are working cooperatively with the

Department of Labor to assure equitable distribution of Title V enrollees. Thus, the proposal is dealing with a perceived problem that does not, in fact, exist or if it does exist, it is on a small scale basis.

Moreover, the vesting of authority in governors to approve plans is contrary to the letter and spirit of existing law. Congress gave the Department of Labor primary responsibility for administering Title V -- not the governors -- because it is a national program with national objectives. This arrangement has contributed to the SCSEP's broad support, and it should be continued.

D. Restore Administrative Cap to 15 Percent

The Asociacion also urges the Human Resources Subcommittee to restore the administrative cap to 15 percent, the same amount that exists for virtually every employment and training program. The 1984 Older Americans Act Amendments reduced the administrative cost ceiling by 20 percent in two stages -- from 15 percent to 13.5 percent on July 1, 1986 and then to 12 percent on July 1, 1987. Unfortunately, this provision will inevitably cause some Title V enrollees to lose their jobs because sponsors must eventually close existing sites in order to consolidate their operations to conform to the lower administrative ceiling.

The lower cap will also quite likely pose problems for the equitable distribution of enrollees throughout a state. This will probably give the program more of an urban bias, although the poverty rate is usually higher for the rural aged than the urban elderly.

E. Consideration for Two-Year Funding Cycle

Asociacion also urges the Subcommittee to consider measures to provide two-year funding cycles for the SCSEP. We believe that this would make the program even more effective administratively. It would allow sponsors to plan more effectively and on a longer-range basis.

It would be beneficial for enrollees and host agencies because they, too, would know with greater certainty the plans for their particular projects. Thus, they would be better able to gauge their conduct.

F. Conclusion

In conclusion, the Asociacion reaffirms its support for the Title V SCSEP. The past track record of the SCSEP demonstrates beyond any doubt that Title V has been exceptionally successful for our nation, older Americans, and the communities that they serve.

The SCSEP deserves to be continued. We believe that Congress should approve perfecting changes for Title V, rather than any fundamental restructuring of this program.

We also strongly believe that our proposals would help greatly to perfect Title V and make it an even more effective program. For these reasons, we urge the Human Resources Subcommittee to adopt these changes.

Thank you again for the opportunity to present this testimony.

POSITION PAPER ON RECOMMENDATIONS TO CONGRESSIONAL SUBCOMMITTEES ON AGING 'S HEARINGS ON REAUTHORIZATION OF THE OLDER AMERICANS ACT:

The San Francisco Coalition of Agencies Serving Minority Elderly *(CASME) aims to improve the economic, social and physical well-being of the older minorities by addressing issues that directly affect our quality of life.In particular, it seeks improved living conditions, better job opportunities, greater participation in public/private programs and agencies, and increased awareness of the status of minority elderly and of our many contributions to the society.

CASME would like to submit its recommendations to both the U.S. Senate and the House's Subcommittees on Aging on the Reauthorization of the Older Americans Act.

I.) CASME is alarmed that Minority participation in Title III programs under this Act has steadily decreased throughout the 80's. The Federal intent of the Older Americans Act, as amended in 1984, is very specific in its language as to whom the services under this Act should be targerted for : " ......**provide assurances that preference will be given to providing services to older individuals with the greatest economic or social needs, *with particular attention to low-income minority individuals,* and include methods of carrying out the preference in the State Plan."**

The status and resources of many minority elderly reflect social and economic discrimination experienced earlier in life. Many, especially those who migrated to the U.S., face cultural and language differences as well. Nearly 4% of older minority Californians have zero or limited English speaking ability. Consequently, minority elderly have increased risks of poor education, substandard housing, poverty, malnutrition and generally poor health.

CASME strongly recommends that the intent of the Older Americans Act be reinstated with emphasis on targeting resources to the low-income minority elderly. Since the State and Area Agencies on Aging are responsible for distribution of the resources, language shoud be added to both State and Area Plans to provide special targeting of OAA funds to minority elderly and special populations. Each State Plan should include a strong Mission Statement on outreach and making services accessible and culturally responsive to minority seniors. It is necessary for language to include bilingual, bicultural programs as specific methods of outreach and services to the minorities. Intrastate Funding Formula (IFF) of each State should reflect targeting older minorities for services in proportion to their needs.

2) CASME recommends strong language be adopted to strengthen and support the advocacy role of Community Based Organizations (CBOs) in Section 305 & 306 of the Older Americans Act. Advocacy is essential and crucial to ensure and increase the participation of more minority elderly in OAA-funded programs.

ADVOCACY, as defined by CASME, is meeting the needs of minority elderly through effective community organization, education, outreach, empowerment of the seniors and seniors-serving network via full awareness and utilization of existing and new resources. Advocacy is also doing what is necessary to eliminate barriers to guarantee services for seniors to be available, accessible and affordable. To meet the social and economic needs of minority elderly, an advocacy role by cultural-unique CBOs is definitely an asset. Without it, participation by minorities is greatly hindered.

We recommend the OAA's intent to fulfill the advocacy role should be spelled out in clear, concise language which will not leave room for misinterpretation and avoidance by the States and Area Agencies, who often are not pursuing this intent vigorously.

3.) There is a great need for Technical Assistance and Training funds for minority elderly serving agencies. As it stands now, community agencies cannot apply for training funds under OAA. In cities with large minority populations, training and technical assistance should be made available to those minority community-based organizations(CBOs) and their national affliates which can play a more appropriate role in providing cultural sensitivity training programs to other aging providers, both public and private. Without additional resources, CBOs cannot take on additional burdens. **CASME recommends that Title IV Training funds be accessible to local and national minority groups and community based service providers.** Emerging minority elderly groups also need technical assistance in outreach and advocacy, to overcome barriers and to compete for grants.

4) CASME recommends special appropriations under OAA Reauthorization directly targeted to minority community-based organizations to develop special programs in advocacy, outreach, nutrition and supportive services to the minority elderly. These special demonstration projects will also provide future data on the causes of the lack of or reduction of minority participation in OAA -funded programs.

5) Cultural and language barriers, along with physical isolation and lower income, often make using health care services difficult to the minority elderly. Minorities also have a shorter life expectancy compared to the white population. Therefore, **CASME strongly recommends that the eligibility for OAA-funded services to remain at age 60.** CASME **opposes to *any* change of this threshold.**

6) In light of the increase of health and safety hazards for the frail elderly following the implementation of the new payment method by Diagnostic Related Groups (DRG) for hospitalization care, **CASME recommends the expansion of Title III Supportive Services to cover for 24-hour In-Home Supportive Services including services for seniors with Alzheimer's Disease.**

7) In 1980, over 2.5 million persons, or 10%, of the population 60 or over in U.S. were non-white. In California, the minority elderly population constituted 679,139 or 17 % of its 60+ population. In San Francisco, Asians, Black and Hispanic seniors make up almost 32%, or 43,347 of the 60+ polulation, which in 1980, was 20% of the city population, or 137,681 in total. San Francisco, thus, by sheer statistics, leads the nation in minority elderly and is a pioneer in providing a wide range of services to them that are unique and culturally sensitive.

San Francisco, despite its success in serving minority elderly, is burdened with a high concentration of economically and socially disadvantaged seniors and families attracted to the city by its receptive social climate and its cultural diversity. Federal programs are not providing adequate help to this group of underserved seniors, as evidenced by the ever-increasing number of homeless, poor, minority elderly who roam the streets of San Francisco every night.

CASME recommends Federal initiatives under the Older Americans Act be aimed at cities with exceptional high concentration of minority seniors, such as San Francisco, to maximize resources for this group of needy seniors by close linkage of government programs with local community-based organizations who have proven their effectiveness in serving their seniors. " Self-determination " has been the underlying principle for many successful anti-proverty programs which began their mission in the 1960's, survived the 70's and are thriving community agencies in the 80's. If the intent of the OAA is to provide services to the minority seniors, the best approach will be to work closely with each minority community's focal point, usually a CBO with bilingual, bicultural programs, to guarantee maximum participation by low-income, minority seniors.

8) **CASME supports a minimum of 5% increase for the new appropriation for the Older Americans Act.** However, recognizing the alarming reduction of minority participation in its programs in light of the demographic changes of our minority elderly population, **we strongly recommend new monies be earmarked specifically to increase minority participation in ALL OAA-funded programs**. Each State and Area Agency on Aging should be required to conduct annual Needs Assessment for its low-income minority senior population. Allocation of federal funds should be closely tied to whether that area meets the needs in proportion to its minority elderly population. The new appropriation should have "teeth" in its language so that each State and each Area Agency fulfills the federal intent of targeting resources to the minority elderly population.

9) Even with the proposed 5% increase, CASME is fully aware that there will never be adequate funding to meet all the needs of minority elders. **We therefore urge for congressional leadership to identify NEW sources of funding to meet such needs.** A special appropriation can be set aside as "incentive funds" for States, Area Agencies or minority CBOs who can secure additional funding from the private sector to implement more services for the minority seniors.

Despite United States's acclamation as a World Leader, it is not known for its respect and care of its elderly. Older people, particularly those from the third world countries, often suffer " cultural shock " by the way seniors are treated here. It is a fact that the U.S. extols youth and disregards seniors.

CASME strongly urges our Legislators to seize this opportunity to restore the love, respect and comfort for its older Americans, with special emphasis for the minority elderly. With foresight, determination and commitment, the reauthorization of the Older Americans Act in 1987 can become the guiding light for senior services and programs that are culturally unique to maximize participation by the minority elders.

In closing, CASME puts forth the challenge to both House and Senate Subcommittees on Aging of recommending amendments to the Older Americans Act that will ensure minority access to services and to enhance the status of minority elderly in the U.S. CASME believes that, together, minority, and non-minority elderly can enrich each other's lives and achieve the goal of a secure, fulfilling life for all older Americans.

Prepared by Anni Chung
April 21, 1987

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TESTIMONY OF

Carl Eisdorfer, Ph.D., M.D.

on behalf of

AMERICAN NURSES' ASSOCIATION

AMERICAN PSYCHIATRIC ASSOCIATION

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

to the

U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEE ON HUMAN RESOURCES

Hearing on the "Reauthorization of the Older Americans Act"

April 8, 1987

The Honorable Dale E. Kildee, Chairman

On behalf of the American Nurses' Association, the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers, I am pleased to present this testimony for the record on the House Education and Labor, Subcommittee on Human Resources' hearing on "The Reauthorization of the Older Americans Act." We welcome this opportunity to comment on the mental health care needs of older Americans.

The American Nurses' Association (ANA), comprising 53 state and territory constituent members, is the national professional organization representing the interests of the nation's professional nurses. The purposes of the ANA are to work for the improvement of health standards and the availability of health care services for all people; to foster high standards of nursing; and to stimulate and promote the professional development of nurses and advance their economic and general welfare.

The American Psychiatric Association is the nation's oldest medical specialty society, representing over 33,000 psychiatrists nationwide. The objectives of the Association include: improving the treatment, rehabilitation, and care of the mentally ill, mentally retarded, and emotionally disturbed; fostering cooperation of all who are concerned with the medical, psychological, social, and legal aspects of mental health and illness; and promoting the best interests of patients and those actually or potentially making use of mental health services.

The American Psychological Association, representing over 87,000 members, is the nation's major psychology organization. The Association works to advance psychology as a science, a profession, and a means of promoting human welfare by promoting responsive concern by the profession on a variety of social and public policy issues; disseminating psychological knowledge to enhance and increase human progress and well-being; developing standards of education, ethical conduct, and professional practice; promoting research; and improving research methods and conditions.

The National Association of Social Workers (NASW) is the largest organization of professional social workers in the world, with over 102,000 members nationwide. The primary objectives of NASW include: promoting the quality and effectiveness of social work practice; improving social conditions through the utilization of professional knowledge and skills; and providing opportunities to work toward alleviating or preventing deprivation, distress, and strain through social work practice and social action.

Our primary concern is the need for a coordinated approach to the delivery of mental health and social services to older persons living in the community. As the Subcommittee develops its amendments to the Older Americans Act, we urge that the needs of older persons with mental and behavioral disorders, and other severly impairing conditions, become a priority issue. We believe the Act can, and should, serve as a legislative foundation for programs designed to reach many of the nation's elderly in need of information about, and access to, mental health and social services. However, before detailing our recommendations and concerns in this regard, we believe it is important to describe the populations with whom we are most concerned, and to point out some serious obstacles to meeting the care needs of these populations.

Mental Health Needs of Older Persons: Background

While most older persons are emotionally healthy, it has been estimated that 10% to 28% of older Americans living in the community (2.6 to 7.3 million individuals) have mental disorders serious enough to warrant professional attention. Unfortunately, it has also been estimated that over 80% of the elderly in need of mental health services will not receive them.

Older persons who are in need of mental health services are a heterogenous population, but may be grouped into three broad categories. These categories represent different etiological factors for the mental disorders and may represent different service needs. First, individuals with a history of chronic mental impairment who have reached old age. The predominant mental disorders of persons in this category include: schizophrenia, severe depression, severe character disorders, and chronic addictive disorders. Many of these individuals were once residents of state psychiatric hospitals, but were transfered to nursing homes and board and care facilities during the deinstitutionalization movement begun in the 1960s. Some have become homeless persons. These older individuals are sometimes participants in senior centers and nutritional sites.

The second category includes older persons who develop mental disorders in later life, with no prior history of impairment. The predominant disorders in this category include anxiety disorders, dysporia and major depression, a high suicide rate (men over the age of 75 have the highest rate for all age groups), social withdrawal, poly drug use and misuse (and confusion about) prescription drugs, alcohol abuse, organic brain syndrome, and dementia (including Alzheimer's disease). Persons in this category are more likely to reside in the community and be cared for by their family.

The third category includes individuals with mental disorders associated with physical health disorders. Examples of disorders in this category include severe anxiety associated with gastrointestinal complications, hearing loss that may lead to delusions and social withdrawal, and cardiac disease and depression. The interaction between mental disorders and physical illness in the elderly is only beginning to be understood, and is a focus of continuing research.

In addition to the three categories noted here, many mental health professionals believe that older persons could benefit from mental health services directed at helping them cope with circumstances that may contribute to the development of mental disorders, such as stressful living conditions, social isolation, bereavement, and the demands of serving as a caregiver to a severely impaired family member.

Older persons with mental disorders differ from other age groups in that they are more likely to have multiple comorbidities. The aged may have overlapping and interdependent medical, social, behavioral, and mental problems, requiring the attention and coordination of service systems as well as service providers.

Underservice of Older Persons With Mental Disorders

Research and clinical experience has demonstrated that older persons do respond well to appropriate psychotherapeutic, psychopharmacological, behavioral, and social interventions, and that these interventions can be effectively provided on an outpatient basis. But, unfortunately, the aged rarely receive the mental health services they need. This is true for both our public and private mental health systems.

Under the current federally initiated service system, community mental health centers (CMHCs) are the designated community agencies providing mental health services to older adults, as well as to younger populations. Yet CMHCs are meeting the needs of only a few of the elderly. The Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging conducted nationwide surveys and site visits, in 1983 and 1985, to determine the quality of services being delivered to older persons by CMHCs and the level of coordination between CMHCs and area agencies on aging in service delivery. Their report, Mental Health Services for the Elderly, documented that although the aged comprise 12% of our national population, they comprise an average of only 6% of the CMHC clinical population. While some centers provide superb services to the aged, many serve almost no elderly. The Action Committee report further documents a deteriorating trend in the number of services for the elderly, a decrease in the number of staff trained to deliver geriatric services, and a decline in outreach programs to locate elderly in need of services.

Older persons are underserved throughout the mental health delivery system, including private mental health practice and nursing homes. Overall, private practitioners provide only 3% of their services to older clients, and fewer than 1% of nursing home residents have access to mental health assessment and treatment.

This is a serious situation for the elderly. At a time when there are more older persons in need of services, the level of care available is declining. This situation needs to be reversed. The associations represented here today are greatly concerned about the lack of adequate mental health services for our nation's older adults.

Factors Contributing to Inadequate Service

The pattern of inadequate service to the elderly persists as a result of a combination of factors: reimbursement structures under federal health programs; a reduction of federal mental health funding under the Alcohol, Drug Abuse, and Mental Health Services block grant; the continued fear and stigma that still haunt our national conception of mental disorders; and the fragmented, disorganized system of mental health, physical health, and social service programs for the elderly. While we recognize that several of these issues do not fall within the Subcommittee's jurisdiction, we believe an overview of the problems is essential to an understanding of the impediments to mental health care for older Americans.

Federal Reimbursement System

In considering federal reimbursement systems for those with mental disorders, it is a sad commentary that today's Medicare system fails to assure that older persons receive adequate and necessary mental health care. It is important that this Subcommittee, as well as the Ways and Means Committee, become aware that Medicare has institutionalized the bias against those suffering from nervous and mental disorders through its discriminatory coverage of mental health benefits. Medicare Supplementary Medical Insurance (Part B), an optional program for the elderly, has an outpatient mental health benefit which contains numerous disincentives for choosing the most cost effective site for services. Reimbursement is limited to $250 annually, and is based on a formula which effectively requires a 50/50 co-payment by the patient, in contrast to the 20% co-payment for the cost of physical health care. This imposes a significant burden for the older patient, who is less likely to have additional insurance coverage for such services. Medicare also restricts services to older persons in need of inpatient treatment by placing a lifetime limit for inpatient care of 190 days in a psychiatric hospital. These burdensome restrictions serve to severely constrain both outpatient and inpatient treatment of older persons. Medicare's failure to provide adequate coverage for the treatment of mental disorders is not within the purview of the Subcommittee. However, we believe it is important that the Subcommittee recognize that this barrier to adequate health care for the elderly with mental disorders stands in the way of many of our mutual goals.

The Alcohol, Drug Abuse and Mental Health Services Block Grant

Enacted in 1981 under the Omnibus Budget and Reconciliation Act, the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant reflects the Administration's philosophy of decreasing federal service funding and reducing the direction given to states on program priorities. The amount of federal funding for community mental health services under the ADMS block grant has been severely reduced over the past six years and has resulted in a decline in services to older persons. Concurrent with the 1983 implementation of the block grant was an immediate 25% decrease in federal expenditure for alcohol, drug abuse, and mental health services. Between 1981 and 1987 there was a $54 million budget decrease, from $549 million to $495 million, which was compounded by a 17.4% increase in the inflation rate during the same time period. The substantial decrease in federal funding under the ADMS block grant has placed considerable pressure on states to increase their mental health budgets. And while states have generally provided more mental health funding, the increases have barely kept pace with the rate of inflation. As a result, public funded mental health services have decreased in many areas, and the aged remain an underserved population within the community mental health system.

Stigma of Mental Disorders

The Subcommittee can help make a difference in another area which serves to segregate the elderly with mental and emotional problems from the health care and social services networks -- the continuing stigma of mental illness. Due to the stigma often attached to mental illness, and due to their private fears relating to it, many people are reluctant to seek mental health care. Indeed, the person with mental disorders is more likely to delay or reject treatment for their complaint than they would be to seek help for a physical disorder. The erroneous belief often persists that "senility" and "mental decline" are a normal part of aging, that older people naturally grow more pessimistic, rigid, and irascible with age. We believe that it is essential that mental health and aging services organizations work together to eliminate the myths and stigma of mental illness by placing it in its proper perspective, namely that mental disorders can be ameliorated and treated in the same way as many physical difficulties. The existing network of area agencies on aging established under the Older Americans Act can help bridge the gap between the myths surrounding mental disorders and the realities of modern mental health care, and provide the link and access to both the mental health treatment and aging services networks.

Fragmented Service Systems

Although most of the factors contributing to the inadequacy of service to the aged are beyond the scope of the Older Americans Act, one of the issues that can be addressed by the Act is the fragmentation of services to older persons. As the Subcommittee is no doubt aware, there are currently two distinct service systems, community mental health centers and services financed by area agencies on aging, which can potentially serve the psychosocial needs of the older person. Unfortunately, these systems are currently structured as separate, independent systems. The community mental health centers serve only the mental health needs of the individual and the area agencies on aging serve only the social services and nutritional needs of the aged. A 1982 study by the U.S. General Accounting Office, The Elderly Remain in Need of Mental Health Services, found that "many of the services which the mentally at-risk elderly need are social supports, rather than, or in addition to, more traditional mental health interventions." In order to improve service delivery to older persons, the authors of the study called for increased cooperation among primary care, mental health, and social service providers. The Action Committee report, cited earlier, supported the GAO findings, documenting that there is little routine interaction and almost no cooperation in service delivery between the two service systems. However, the Action Committee study also found that community mental health centers and area agencies on aging are well aware of the mental health needs of the aged and believe there should be more cooperation between the mental health and aging services networks in the delivery of needed services. Such findings pose a major challenge to both the aging network and the mental health care system. The amendments we are proposing to the Older Americans Act address the need for cooperation and interaction between the mental health and aging service systems at the federal, state, and local levels.

Recommendations for Amendments to the Older Americans Act

The groups endorsing this testimony believe that the Older Americans Act needs to be strengthened to provide older adults greater access to mental health and social support services. In developing these recommendations we have collaborated with a wide range of aging planning and services organizations, aging constituent organizations, national mental health organizations, disability and rehabilitation organizations, and professional associations. We are confident that these recommendations are a cost effective means of improving mental health care for the elderly. In summary we recommend:

First, that Functions of the Commissioner, under Title II of the Act, be amended to include providing assistance in the establishment and implementation of programs to meet the needs of older individuals for mental health services and address the needs of older persons with such severely impairing conditions as developmental disabilities, stroke, physical and sensory impairment, and mental disorders (including but not limited to

Alzheimer's disease and related disorders). As older persons with severely impairing conditions, including mental disorders, have often been overlooked in service planning, we believe the Commissioner should give particular attention to addressing their needs.

Second, that Title III of the Act be amended to:

a. Encourage the development of cooperative working agreements between State Agencies and State Departments of Mental Health and between Area Agencies on Aging and local Community Mental Health Centers in meeting the mental health and social service needs of the elderly.

b. Encoruage the development of cooperative working agreements between State and Area Agencies with other State agencies who primary responsibilities are for individuals with mental retardation, developmental disabilities, or other handicapping conditions.

c. Assure that Area and State plans include mental health services and address the needs of older persons with severely impairing conditions.

Third, that Title IV of the Act be amended to:

a. Include reference to older persons with special needs, such as disabilities and mental disorders (including Alzheimer's disease and related disorders), in all relevant sections.

b. Make grants available for the training of Title III service providers and nursing home care providers to meet the special service needs of elderly with mental disorders, and other severely impairing conditions, who are residing either in the community or in nursing care facilities.

Finally, we believe that these recommendations can be implemented under the existing resources of the Older Americans Act. As these recommendations encourage planning and coordination efforts between agencies and departments, and allow for competition for grant awards, they do not require a redirection of Older Americans Act resources or an additional appropriation for implementation. We are, however, supportive of the Older Americans Act budget increases recommended by other groups, and believe that the valuable services provided by the Act should be expanded to meet the needs of additional older persons.

We thank the Subcommittee for the opportunity to express our views on the Older Americans Act. We will continue to support this Subcommittee's efforts to improve the care of this nation's older population. We would be pleased to work with the Subcommittee in drafting the final amendments and report language necessary to carry out these recommendations.

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

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STATEMENT OF

FORMER CONGRESSMAN JAMES ROOSEVELT

CHAIRMAN OF THE NATIONAL COMMITTEE

TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO

THE COMMITTEE ON EDUCATION AND LABOR

SUBCOMMITTEE ON HUMAN RESOURCES

U.S. HOUSE OF REPRESENTATIVES

REGARDING

OLDER AMERICANS ACT REAUTHORIZATION

APRIL 6, 1987

I am James Roosevelt, Chairman of the National Committee to Preserve Social Security and Medicare. In that capacity, I represent more than four million members. Most of our members, age 60 and over, are benefactors or potential benefactors of programs authorized under the Older Americans Act. I, therefore, appreciate the opportunity to express the views of the National Committee on the reauthorization of the Older Americans Act.

Although the overall funding of the Older Americans Act is insignificant compared with other social programs, the Older Americans Act has been highly successful in enhancing the lives of more than nine million seniors across the country every year. It also serves the important function of setting a national policy for how we as a nation strive to treat our senior citizens.

"...in keeping with the traditional American concept of the inherent dignity of the individual..." the Older Americans Act states that seniors should have equal opportunity to adequate income; the best possible physical and mental health that science can make available without regard to income; adequate housing; restorative institutional care; a comprehensive array of community services; employment without discrimination; healthy, dignified retirement with access to worthwhile activities; efficient community services including low-cost transportation; benefit from new, proven research; and, finally, the freedom and independence to manage and plan their own lives.

This is a large mandate for a program with only one billion dollars in appropriations. The only way the Older Americans Act can begin to meet such a broad charge is by coordinating existing programs and advocating for additional services. Advocacy at all levels of government as well as the private sector is at the core of the Older Americans Act.

Advocacy: Clarify Guidelines

From the beginning, the Older Americans Act was designed to provide services to seniors not adequately served by other public and private programs. Perhaps even more important, the mandate was to advocate at the Federal, state and local level to encourage a more responsive attitude to the needs of older people.

The current Administration has tried to place a rein on advocacy under the Act. A few years ago, the Office of Management and Budget issued a ruling, the so-called A-122 Circular, which restricted organizations receiving Federal funding from interacting with legislative bodies. This rule clearly conflicts with the mandate of the Older Americans Act, and yet it reportedly has placed a damper on advocacy efforts by people working under the Act. Whether advocating for older Americans in the community or in institutions, it is important that the people doing the advocating have clear guidelines about what they can and cannot do. This confusion is unfortunate and should be cleared up once and for all with appropriate language in the authorization legislation.

Advocacy: Raise Status of Commissioner

The Older Americans Act provides for advocacy on behalf of senior citizens within the Federal government as well. The Federal Council on Aging is responsible for reporting to the President on aging-related matters. The Administration on Aging, headed by the Commissioner, runs most programs under the Older Americans Act. Many have criticized the Council and the Commissioner over the years for not being stronger advocates for seniors. At the same time, the Commissioner has only minor status within the Department of Health and Human Services. For years the idea of raising the Commissioner's position to the level of Assistant Secretary has been suggested. We support this proposal because it would give the job more visibility and more authority, reduce red tape, and could permit the Administration on Aging to function as a stronger, more viable advocate for seniors in this country.

Advocacy: Funding

The National Committee supports an increase in the authorization level of the Older Americans Act of at least five percent in each of the reauthorized years. The need is even greater, but Congressional appropriations are only 85 percent of authorized levels.

We would urge Congress not to consider the Administration's proposal for a "generic appropriation" approach to the Older Americans Act. It would pit human service providers against each other in their efforts to lobby for funds for their programs. The competition will be stiff because the overall funding for these programs will total $69 million less than they are currently receiving. Furthermore, it will reduce Congressional control over spending while giving the Administration greater leverage to force program managers to "play ball" in administering programs and advocating for more funding.

Advocacy: Outreach and Referral

An important function of the area agency is to inform seniors about available resources. Knowledge of a service is the first step in utilization. This is done through telephone information and referral services and through outreach into the community. Outreach has not received enough emphasis in the last few years because of scarce resources and because of the fear that too much publicity will bring too high utilization of already limited services.

Outreach should not be neglected, however. It is important for seniors to be aware of the existence of the area agencies so that they will know where to turn should they need services. A recent Louis Harris survey of senior citizens living alone found that sixty percent of respondents could not name an organization to which they might turn if they needed help. The same study also found that almost half of the poor seniors potentially eligible for Supplemental Security Income (SSI) had never even heard of the program. Although it is not solely the responsibility of the area agencies to provide information about the SSI program, it does indicate the serious need for more outreach to the older population. This component should be strengthened if not in the Act itself, certainly in the report language.

Advocacy: The Need for More Long-Term Care Services

Home Care. We want to commend the Chairman for his proposal to add a new section to Title III, with a $25 million authorization for the purpose of providing in-home services such as homemaker, chore and respite to frail older citizens. This proposal responds to the documented need for more in-home care. Not only do seniors released from the hospital earlier require more intensive care in the home, but the older, more frail population with chronic conditions also requires assistance. The need is constantly growing as the population ages. By the turn of the century we can expect the aging population to have grown by 27 percent -- to make up 17 percent of the total population. In addition to the Chairman's proposal, Congressman Rinaldo's bill, H.R. 1626, proposes to make home health service grants available to states with a first year authorization level of $50 million. The National Committee strongly supports these efforts to strengthen the in-home component of the Older Americans Act.

Adult day care is another example of a service necessary to meet the growing need of aging members of our society, yet only about 25 percent of area agencies across the country subcontract for this service. Day care for the frail elderly serves to provide stimulation and socialization for seniors while it lets the caregiver attend to other family matters. Day care can also make the difference between the caregiver being forced to give up his or her job, and maintaining work outside the home. To encourage the development of more adult day care, the National

Committee proposes to make these services a priority under the Act for the next reauthorization period.

Respite. This nation is estimated to have between 2.5 and 3 million victims of Alzheimer's disease and related dementias. Many victims are in the early stages of the disease and are being cared for in the community by family members. These family caregivers of Alzheimer victims and other mentally and physicially frail older people desperately need respite services to keep going in the often very exhausting and exasperating job of caregiving. Adult day care and in-home services can provide invaluable respite from the daily caregiving responsibility. Senator Metzenbaum has introduced a proposal to create a home and community-based services block grant for victims of Alzheimer's disease and related dementias. The National Committee urges the Committee to consider such a proposal.

Volunteer Work Credits. As we age, we require more help from others -- help that is often difficult to accept. Americans traditionally have been brought up to be self-reliant and independent. Congressman Wyden has proposed an innovative volunteer exchange program which should make it easier for seniors to accept help from others. Older people would perform services for other seniors in exchange for work credits which, in turn, would get them free help in the future when they need it. These services would include such things as shoppping, home repair and homemaking. One survey found that twenty-five percent of seniors said they would be willing to volunteer on this basis. If these millions of older people volunteered just a few hours every week, it would translate into several billion dollars worth of help to seniors from other seniors. This idea should be implemented.

Advocacy: Legal Assistance

Older Americans often need legal assistance in asserting their rights to Social Security, Supplemental Security Income, Medicare and Medicaid benefits and to resolve housing or other consumer problems. Legal assistance is sometimes required to negotiate the bureaucracies and red tape encountered in trying to resolve benefit problems. Other times more serious legal problem arise. Many seniors do not know how to get help and frequently they cannot afford to hire a lawyer.

At a recent House Aging Committee hearing on legal services to the elderly, several case example were outlined. One such case was a 65-year-old woman with a broken hip who was neglected by her son. He left her immobile on a couch for three weeks, feeding her on average only once per day. Legal Services of Eastern Michigan obtained an injunction removing him from the house, returning her assets and arranging for nursing home care. Another example was a 73-year-old man who was being evicted from a senior citizens housing complex because the management considered him to be "too disruptive." His offense was changing the channel on the lobby televison too often. Eviction proceedings were successfully defeated.

One of the three priority service areas of Title III-B is to provide legal assistance for seniors. Although the Act states that "an adequate proportion" of III-B funds should go towards each of the three priority areas, nowhere in the Act or its implementing regulations is the "adequate proportion" language defined. A recent survey of legal assistance under the Older Americans Act, prepared by the American Bar Association's Commission on Legal Problems of the Elderly, found that funds for legal help under the Act have declined nearly 50 percent since 1980 after adjustment for inflation. In 1980 the average area agency on aging spent six percent of Title III-B funds on legal services. The National Committee recommends that the funding for legal assistance to the elderly be restored to the 1980 level by requiring six percent of Title III-B funding to be set aside for this purpose.

Advocacy: Nursing Home Ombudsman Program

The Older Americans Act also mandates advocacy for the institutionalized older person. Nursing home reform is one of the National Committee's highest priorities. Last year, we proposed a five-point plan for nursing home reform which called for improving inspections and strengthening enforcement of penalties for violations. We also called for a stronger Long-Term Care Ombudsman Program, the program charged with helping residents, families and friends of relative to resolve complaints and correct abuses.

To find out what kinds of problems our membership has encountered with nursing homes, we requested our members to write letters. In response, I received hundreds of letters from people across the country detailing experiences with nursing home abuse. A summary report of this information will be released soon from the the National Committee. One clear and uniform impression emerged from these letters, namely that basic human rights are being violated in too many nursing homes. For instance, respondents often complained of such things as not being able to reach drinking water, of room temperature being too hot or too cold, or of a radio played in spite of constant requests that it be turned off. Often nursing homes are understaffed and residents have to wait for long periods of time before there is a response to their call. A letter from a resident states: "I can't think of anything worse than having a "nature" call and no one coming to assist. Then when the "worst" happens, having to lie in my own waste for hours." Many of the problems described in these letters are the type of which the ombudsman can assist in solving.

Not only are ombudsmen needed in the nation's estimated 10 to 15 percent chronically substandard nursing homes, they are also serving an important role in solving problems between residents and the administration of well-run nursing homes. In one reputable facility in Maryland, the ombudsman was asked to intervene by a resident's daughter. Her mother, against her will, was to be moved to a closed section of the nursing home because her behavior was disruptive to other residents. The daughter was upset because she knew such a move would be detrimental to her mother's well-being. The ombudsman, by gaining access to the patient's records, discovered that the mother most likely was receiving too high a dosage of her behavior modification medicine. The ombudsman negotiated a few days' delay in the move during which time the resident was taken off the medicine. In the next couple of days the resident calmed down and a move was avoided.

The role of the ombudsman needs to be strengthened. Access to patient's records, for example, is not mandated in the Act. The Older Americans Act only sets up a framework and leaves to the states to set up the specifics guaranteeing access to facilities, access to patients and access to patients' records. Only a minority of states have passed ombudsman-enabling legislation since the program became part of Title III in 1975. This is a clear indication that action is necessary on the Federal level.

It is important to begin to look at expanding the Ombudsman Program to other settings where seniors are vulnerable. The ombudsman's responsibilities should be expanded to follow residents to the hospital as Senator Glenn proposed in the 99th Congress. Also, as a demonstration project, ombudsman services should be provided in the home. Congressman Roybal's H.R. 1700 includes this provision. It is essential, however, that no expansion be considered without additional funding.

States are required to designate one percent of Title III funds or $20,000, whichever is greater to Ombudsman services. Nationwide this amounts only to $12 or $13 million. Considering that 1.4 million people live in nursing homes and countless more in board and care facilities, the program is considerably underfunded, especially if the program is expanded, as we believe it should be. The National Committee supports Representative

Pepper's proposal to place the Ombudsman Program under a separate section of Title III and increase the funding to two percent of Title III-B or $100,000.

Representative Pepper's H.R. 395 calls for immunity for the ombudsman and any ombudsman designee. His bill would require increased access to facilities, patients and patients' records and more technical assistance from the Administration on Aging. These provisions would further strengthen the role of the ombudsman and the National Committee strongly supports such legislation.

Advocacy: Innovative Employment Services

Title V of the Older Americans Act, the Senior Community Service Employment Program, brings together both low income older Americans needing and wanting work and communities needing manpower for public services. It is a sensible solution which helps demonstrate the viability of the older worker. The program should be continued and should receive funding in line with authorized amounts.

But it should also be recognized that this program serves a very small percentage of the eligible population. In the last reauthorization, it was with this fact in mind that the Congress set aside funds for programs which emphasized training and placement of enrollees in private sector employment. In doing so, more Title V opportunities for older workers would become available.

These experimental training initiatives have proved promising enough to continue to expand this approach. But greater flexibility and demonstration of "innovation" would be welcome in this area. Because the current national non-profit agencies sponsoring Title V have built on a record of past performance, they have been limited by that same history in the development of truly innovative approaches to more effective placement of enrollees in the private sector.

In fact, with a few notable exceptions, there has been either great resistance to increased goals for placement of enrollees in private sector employment or unenthusiastic, and therefore uninspired, compliance. To address this we recommend that the Act be amended to provide for competitive bidding for administration of innovative training and placement projects.

By taking the step of opening up the innovative component of Title V, Congress can strengthen the training and placement component. It is our view that it is long past time that a few contractors enjoyed a protected monopoly of program design and responsibility.

Conclusion:

In summary, The National Committee wants to make the following recommendatations for the reauthorization of the Older Americans Act:

- clarify that the Older Americans Act is not covered by the OMB A-122 Circular;
- raise the Commissioner's position to Assistant Secretary;
- increase authorization levels by a minimum of five percent;

- authorize new funding for in-home services;
- make adult day care a priority service during the next reauthorization period;
- authorize a block grant for home and community services for victims of Alzheimer's disease and related disorders;
- adopt Congressman Wyden's bill regarding seniors earning volunteer credits;
- strengthen the Long-Term Care Ombudsman Program by creating a new section under Title III; increase funding considerably; mandate access to nursing homes, patients and patients' records; provide the ombudsman with immunity;
- expand the ombudsman mandate to hospitals and bring ombudsmen into the home health setting on a demonstration basis;
- strengthen legal assistance by requiring a 6 percent of Title III-B funding setaside.

Conclusion

Finally we urge you to reaffirm the importance of the Older Americans Act by being as generous as possible when considering the reauthorization funding levels. Five percent may be realistic, but it hardly covers the demand for more services by an ever growing senior population. Let us not forget the objectives of the Older Americans Act - the very quality which makes the Act one of the most enduring symbols of this nation's basic concern for its aging members.

THANK YOU.